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No.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 2001

S. KIMBERLY BELSHE, Director, California Department of Health Services, *Petitioner*,

v.

CHILDREN'S HOSPITAL AND HEALTH CENTER, et al., *Respondents*.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Is a case moot when, as here, retroactive relief is barred by the Eleventh Amendment and prospective relief is barred by repeal of the statute on which the plaintiffs' case is based?

2. May a court order a state to comply with a repealed federal statute ?

3. Should the Ninth Circuit have deferred to the views of the federal government which took the position that the repealed Boren Amendment did not apply to out-of-state hospitals?

4. Did the repealed Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)), relating to reimbursement of hospitals for care rendered to Medicaid recipients, apply to out-of-state hospitals?

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Diana M. Bonta, Director of the California Department of Health Services and successor to former Director S. Kimberly Belshe, respectfully requests this Court to issue a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit which is reported at 188 Fed.3d 1090.

OPINION BELOW

The 2-1 opinion of the Ninth Circuit, including the dissent, is reproduced at Appendix A. The order of the Ninth Circuit denying petitioner's petition for rehearing is reproduced at Appendix B. The two relevant interim rulings of the trial court are reproduced at Appendix C.

JURISDICTION

On August 16, 1999 the Ninth Circuit issued its 2-1 opinion affirming two interim orders of the District Court that stated that the Boren Amendment applied to out-of-state hospitals and that the state had failed to make the findings required by that statute. The state's petition for rehearing was denied on December 17, 1999. This Court has jurisdiction to review the Ninth Circuit's decision pursuant to 28 U.S.C. section 1254(1).

RELEVANT STATUTORY PROVISIONS

A. Relevant Portions of The Former Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)):[1]

The Boren Amendment, which figures prominently in this case, required California to provide "for payment...of the hospital services...provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards to assure that individuals eligible for medical assistance have reasonable

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1. In setting forth the statute in the text we have used ellipsis for conciseness and to facilitate understanding. The full text of the statute is included at Appendix D.

access...to inpatient hospital services of adequate quality...; and such State makes further assurances...for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports..."

B. The Statute Repealing The Boren Amendment

The Boren Amendment was repealed, effective with respect to payment for services commencing October 1, 1997. The repeal is found at P.L. 105-133, section 4711, 11 Stat. 507-508. The text of the repeal is found at Appendix E.

STATEMENT OF THE FACTS

This case involves an aspect of the Medicaid program, known in California as Medi-Cal. The Medicaid program is a cooperative federal-state program which provides federal financial assistance to states which choose to reimburse certain costs of medical treatment for needy persons. (Harris v. McCrae, 448 U.S. 297, 301 (1980).) Although states have the option of whether to participate in the program, if they do elect to participate they must abide by applicable federal statutes and regulations. (See 42 U.S.C. § 1396a.) While the Boren Amendment was in force, to qualify for federal assistance, the participating state was required to submit, and have approved, a state plan which set forth the state's reimbursement methodology. (Ibid.)

The plaintiffs in this case are 18 hospitals which are located in seven states other than California. The gravamen of their complaint can best be illustrated by a hypothetical situation: Assume that Mr. Smith, a

California resident who is on the Medi-Cal program, is driving a car in Phoenix, Arizona. He is involved in an automobile accident and taken to the hospital. The hospital asks him whether he has insurance. He says that he doesn't have insurance but that back in California his medical bills are paid by Medi-Cal. The Arizona hospital treats him and sends the bill to the California Department of Health Services (DHS) which administers the Medi-Cal program. DHS makes a calculation based on a certain methodology and sends the hospital a check.[2] Basically, the plaintiff hospitals in the instant case are saying that the methodology is invalid and that California is paying them at too low a rate.

In a complaint filed on March 28, 1995 plaintiffs alleged that the Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)) required the state to make certain findings with respect to payments to out-of-state hospitals and that the state failed to make such findings. They also alleged that California's payment methodology for reimbursing out-of-state hospitals was arbitrary and capricious and did not take into account the situation of hospitals serving a disproportionate number of low income individuals. Plaintiffs sought injunctive and declaratory relief.

After filing an Answer, the Director of DHS moved for a summary adjudication that the Boren

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2. The methodology is based on California's experience with in-state hospitals. In California some 85% of Medi-Cal reimbursement for inpatient services provided by California hospitals is paid at a negotiated contract rate. (See Cal. Welf. & Inst. Code §§ 14081 et seq.) California pays out-of-state hospitals at the average of the contract rates paid to California hospitals. California does not make so-called disproportionate share payments (DSH) to out-of-state hospitals.

Amendment did not apply to out-of-state hospitals. On January 9, 1997 Judge Marilyn Hall Patel denied our motion and ruled that the Boren Amendment applied to out-of-state hospitals to the same extent it applied to in-state hospitals. The court's ruling was limited to the latter issue; it did not address whether or not the state had violated the Boren Amendment.

Subsequent to the court's first interim ruling the Boren Amendment was repealed, effective with respect to payments for services commencing October 1, 1997. (P.L. 105-133. § 4711, 111 Stat. 507-508.) Notwithstanding repeal of the Act, the trial court made a second interim ruling on February 5, 1998, to the effect that California did not satisfy the "findings" requirement of the Boren Amendment in establishing out-of-state hospital rates.

With permission from the Ninth Circuit, DHS appealed from the two interim rulings of the District Court. We argued the case was moot because of the repeal of the Boren Amendment. On the merits we contended that the Boren Amendment did not apply to out-of-state hospitals. We pointed out that the Health Care Financing Administration (HCFA) agreed with us and that its position should be given deference.

In a 2-1 decision the Ninth Circuit affirmed the District Court. It determined that the case was not moot. It refused to defer to HCFA and, in effect, resurrected the defunct Boren Amendment, ruling that California must apply its provisions to out-of-state hospitals. The dissenting judgment would have deferred to HCFA's view and reversed on that basis. Our petition for rehearing was denied on December 17, 1999.

REASONS FOR GRANTING THIS PETITION

ARGUMENT

I.

THE NINTH CIRCUIT'S FAILURE TO RULE THAT THE CASE IS MOOT IS CONTRARY TO LAW.

Rule 10(a) of the Supreme Court Rules indicates that this Court will consider granting the writ where a United States Court of Appeals "has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power." (U.S. v. Munsingwear, 340 U.S. 36, 40 (1950).) We believe that the Ninth Circuit in this case has interpreted the principle of mootness in a way which is inconsistent with prevailing federal standards and that action by this Court is necessary to assure uniform application of that important doctrine.

No party or court disputes the fact that the Eleventh Amendment bars retroactive relief in this case. The question is whether prospective relief can be granted. We submit that the repeal of the Boren Amendment bars that type of relief as well.

It is axiomatic that Congress may enact legislation that affects pending cases. (U.S. v. The Schooner Peggy, 5 U.S. (1 Cranch) 103, 110 (1891).) It is similarly well established that Congress may repeal a statute which may be the subject of litigation and that courts are bound to apply the law extant at the time of decision. (Seattle Audubon Society v. Robertson, (9th Cir. 1990) 914 Fed.2d 1311, 1315; rev'd on other grounds,

Robertson v. Seattle Audubon Society, 503 U.S. 429 (1992).)

In Green v. Mansour, 474 U.S. 64, 73 (1985) plaintiffs sought injunctive and declaratory relief against state officials for alleged violation of AFDC laws. During the pendency of the action the federal law was amended. This Court affirmed the district court's decision that the change in law mooted the claims for prospective relief. It also ruled that the Eleventh Amendment barred declaratory relief because it would have applied to past violations of federal law. (Id. at 67.)

Similarly, in Diffenderfer v. Central Baptist Church, 404 U.S. 412 (1972) the plaintiffs attacked a statute which granted a church a tax exemption for certain activities. During the course of the litigation that statute was repealed and a new one enacted which, in essence, eliminated the exemption. This Court stated, "The only relief sought in the complaint was a declaratory judgment that the new repealed [statute] is unconstitutional as applied to a church parking lot used for commercial purposes and an injunction against its application to said lot. This relief, is, of course, inappropriate now that the statute has been repealed. (Id. at 415; emphasis added.)

II.

IN RESURRECTING A REPEALED STATUTE THE NINTH CIRCUIT HAS VIOLATED THE SEPARATION OF POWERS DOCTRINE.

In rejecting our mootness argument the Ninth Circuit relied on a sentence in a December 10, 1997 HCFA letter sent to the states regarding their obligations under the statute which replaced Boren. We respectfully suggest that the Ninth Circuit has misread the intent and effect of the HCFA letter. That letter was intended to provide guidance to states with respect to procedures they could employ following the repeal of the Boren Amendment. It said, in essence, that if HCFA had approved the state's reimbursement scheme, that scheme could be utilized in lieu of the procedures permitted under Boren's successor statute.[3] In light of HCFA's position that Boren did not apply to out-of-state hospitals, that meant that California's method of reimbursing out-of-state hospitals was unaffected by the repeal of the Boren Amendment.[4] In other words, if Boren never applied to out-of-state hospitals in the first place, then the repeal of Boren was irrelevant. What mattered was whether HCFA

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3. HCFA's letter of December 10, 1997 addressed only the states' obligations under the new federal law that replaced the Boren Amendment. The court below relied on one sentence in which HCFA said "states are not required to subject their existing rates to a public process to the extent that those existing rates were validly determined in accordance with legal standards in effect prior to October 1, 1997."

4. We acknowledge that our reimbursement system (see fn. 2, *ante*) might be imprecise but overall it is fair. Indeed, in many cases, it results in a rate higher than the hospital would receive from its own state. In any event, it is this system to which HCFA has given its imprimatur.

had approved the non-Boren methodology by which California had reimbursed out-of-state hospitals.

What the Ninth Circuit is saying is something quite different. It is reading the HCFA letter to mean that HCFA is declaring that California, if it does not adopt the new statutory procedures, must apply the repealed Boren Amendment requirements to out-of-state hospitals. This is obviously contrary to law and contrary to HCFA's intent. HCFA said it did not believe that Boren applied to out-of-state hospitals. We respectfully suggest that, in fairness, the Ninth Circuit cannot rely on HCFA's letter to link California to prior procedures and then refuse to agree with HCFA that those same procedures did not require compliance with Boren. Clearly, HCFA did not intend that its letter be used as a vehicle for the court to take a position with which HCFA disagreed.

Quite simply, the Ninth Circuit is saying that despite its repeal, Boren lives. The fact is that the Boren Amendment was repealed and no court or administrative agency can compel prospective compliance with a statute which is no longer on the books. That constitutes legislating, which violates the doctrine of separation of powers. (U.S. Const., Art. I, sec. 1.) We submit that neither the circuit court nor HCFA has the power to resurrect a defunct statute; only Congress can do that. Nor can HCFA or the Ninth Circuit abrogate the states' Eleventh Amendment rights. In sum, the Ninth Circuit should have ruled that the case is moot. It was error for the court to conclude that the HCFA letter revives the Boren Amendment and to force us to terminate the method by which we reimburse out-of-state hospitals.

III.

THE NINTH CIRCUIT SHOULD HAVE DEFERRED TO THE VIEWS OF THE FEDERAL GOVERNMENT.

At the invitation of the district court HCFA filed an amicus brief in this case. It took the position that the Boren Amendment did not apply to out-of-state hospitals. It said that it is "virtually impossible for States to comply with the Boren Amendment with respect to out-of-state providers." It also said that "in the decade and one half since Congress enacted the Boren Amendment, the Secretary's actions corroborate her view that the provision does not apply to out-of-state facilities." Despite the fact that the district court had solicited the views of HCFA, the court refused to give any weight to those views.

The Ninth Circuit also dismissed HCFA's position on the dubious ground that "Congress has unambiguously addressed the issue." (App. A, p. 3a.) It is hard to understand how the majority could conclude that the Boren Amendment unambiguously applied to out-of-state hospitals. This entire case abounds in ambiguity; it revolves about the fact that neither the statute nor the legislative history expressly addresses the principal question and that we must interpret the statute and hunt for clues as to Congressional intent.[5/]

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5. Among the ambiguities created by the statute are the following: 1) The Boren Amendment required "the filing of uniform cost reports by *each hospital* ... and periodic audits by the state of such reports." (Emphasis added.) Does this mean that California must obtain cost reports from every hospital in the land that treats a California resident who is on Medi-Cal? Does it also mean we must send an audit team to each hospital? 2) A provision of the Boren Amendment required states to take into account the situation of hospitals which treat a disproportionate share of poor people.

Not surprisingly, the dissent disagreed with the majority on this point, noting, "The majority improperly concludes that the Boren Amendment is unambiguous. In so doing, it ignores the reasonable interpretation of a statute proposed by the administrative agency charged by Congress to implement it. This, of course, ignores the teaching of Chevron, U.S.A., Inc. v. Natural Resources Defense Council, 467 U.S. 837, 843, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984). The Boren Amendment is ambiguous and HCFA's interpretation of the statute is permissible. Therefore, I would reverse the decision of the district court." (188 Fed.3d at 1099.)

As we pointed out earlier, we believe that the Ninth Circuit has disregarded fundamental rules which apply to the doctrine of mootness. We also believe that it has acted in derogation of the well-established principle that the views of a federal agency charged with implementing a statute should be given deference and, indeed, controlling weight. (Chevron, supra, at 842.)

Whether these provisions apply to out-of-state hospitals is not expressly addressed by the statute. If anything, the language of the statute which speaks in terms of applying the provisions only to the participating state (see discussion, *infra*, at p. 13), militates toward the conclusion that the Congress did not intend Boren to apply to out-of-state hospitals. At the very least these considerations illustrate that the statutes involved are ambiguous. Accordingly, the lower court should have deferred to HCFA's interpretation.

IV.

THE NINTH CIRCUIT'S RULING WAS SUBSTANTIVELY INCORRECT AND WILL HAVE A NEGATIVE IMPACT ON OTHER STATES.

As we demonstrate below, the Ninth Circuit's ruling on the merits was erroneous. If the decision stands, it can be cited across the country to compel states to continue to comply with the Boren Amendment and to apply it to out-of-state hospitals. Indeed, it could be used to force a state to pay out-of-state providers pursuant to the Boren Amendment even though, for in-state providers, the state ceased complying with that statute after it was repealed. Although California has not complied with the Boren Amendment for in-state providers since Boren's repeal, the Ninth Circuit ordered it to do so for out-of-state providers. This order results in an anomaly and should be reversed by this Court.

A. Congress Intended to Limit the Statute to In-State Institutions

To determine whether Congress intended that the Boren Amendment would apply to out-of-state hospitals we must examine legislative history as well as the actual language Congress used in the enactment. The legislative history is sparse. However, in the committee report which accompanied OBRA 1981 it was stated, "The Committee believes that payment levels should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals available in the State." (H.R. Rep. No. 58, 97th Cong., 1st Sess., vol. II, 293 (1981); emphasis added.) Note that the report does not say "in every state" or "in all states"; it is restricted to

those hospitals within the particular state implementing the federal statute.

This theme also ran through the pertinent statutes. For example, the DSH component of the Boren Amendment required the state to comply with the provisions of 42 U.S.C. § 1396r-4. These provisions uniformly refer to the circumstances of hospitals only within the participating state. For example, 42 U.S.C. § 1396R-4(B)(1)(A), in defining a DSH institution, refers to hospitals "receiving medicaid payment in the state." (Emphasis added.) Similarly, § 1396r-4(f)(1)(A) speaks of hospitals "in a state." And § 1396r-4(f)(1)(A)(i)(I)(b) refers to a "statewide" arithmetic mean. Further, § 1396r-4(f)(1)(D)(i) and (ii) refer to a utilization rate "for all hospitals in the state." Also, § 1396r-4(e)(ii) refers to a "statewide" pooling arrangement.

It is apparent that the complex calculations employed to determine whether a hospital is a DSH institution and how much additional reimbursement it may claim, were meant to apply only to institutions within the participating state. We have found no statutes or legislative history which indicate that these calculations were to be made by each state with respect to hospitals in every other state.

The primary basis for the Ninth Circuit's decision was its conclusion that the term "hospital services" in the Boren Amendment's payment provision unambiguously applied both to in-state and out-of-state hospitals. It reached that conclusion because the statute does not expressly differentiate between in-state "hospital services" or out-of-state "hospital services." Because of that conclusion, it gave no deference to the federal government's interpretation that the Boren Amendment applied only to in-state hospitals. We respectfully submit

that the Ninth Circuit's analysis is unpersuasive on this point and that the language we have cited, taken together with the administrative considerations set forth below, combine to negate the Ninth Circuit's interpretation.

We must also point out a glaring inconsistency in the lower court's decision. On the one hand, it held that the Boren Amendment applies to out-of-state hospitals. On the other hand, it concluded that the cost report/audit provision of the Boren Amendment applied only to in-state hospitals. The latter provision requires that each state make "further assurances ... for the filing of uniform cost reports by each hospital ... and periodic audits by the state of such reports." We agree that the cost report/audit provision applies only to in-state hospitals. We submit, however, that if the term "each hospital" in that portion of the Boren Amendment applied only to in-state hospitals, there is no logical basis for the Ninth Circuit's conclusion that the term "hospital services" in the payment provision unambiguously applied to both in-state and out-of-state hospitals.

We believe the lower court created the distinction because it realized that administrative chaos would result if the cost reports and audit language of the statute were applied to out-of-state hospitals. It would be a virtual impossibility for the State of California to obtain cost reports from, and perform audits of, every hospital in the country that happens to treat a California resident who is on Medi-Cal.[6] The Ninth Circuit dealt with this problem by concluding, in essence, that the state could ignore these Boren Amendment requirements and find

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6. This burden would obviously apply to other states as well. Thus, if an Alaska resident, for example, is treated in a hospital in Minnesota, the Alaska authorities would be compelled to obtain cost data from and perform an audit of the Minnesota hospital.

other ways to obtain the necessary cost data. We submit that this approach is plainly contrary to the language of the statute.

There is another Boren provision we should mention. The Act requires that Medicaid patients have reasonable access to hospital facilities. These inquiries obviously require intimate familiarity with topography, demographics, traffic patterns, public transport, etc. -- matters which are logically within the expertise of local state officials. If this provision applies to out-of-state hospitals, we would either have to send California officials to other states to determine whether the subject facility provides reasonable access, or demand lengthy reports and analyses which would give us that information. Neither option makes sense. This point was not addressed by the Ninth Circuit.

Finally, we note that similar Boren provisions applied to nursing facilities. The Act required the state to take into account the costs "of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident...". California can make these determinations for California residents but it can hardly do so with respect to other states where California residents may be receiving services. Suppose, for example, a California resident is in a nursing home in Wheeling, West Virginia. Are we supposed to send California officials to West Virginia to ascertain whether that California resident is having her psychosocial needs met? Do we demand reports from social workers and nursing home supervisors to satisfy the statutory requirements?

B. Applying Boren to Out-of-State Hospitals Would Impose An Intolerable Administrative Burden Not Intended by Congress.

In the court below we described the intolerable administrative burden which would result from applying the Boren Amendment to out-of-state hospitals. In dismissing our argument the Ninth Circuit, in essence, rewrote the statute to minimize such problems. The court said, "The weakness in Belshe's argument is that she presumes the Boren Amendment requires states to apply the same methodology and administrative requirements to out-of-state hospitals that states apply to in-state hospitals. This is not so." (188 Fed.3d at 1098.) The court then asserts that California can reduce the administrative burden by using different methodologies for out-of-state hospitals.

Nothing in the statute or in the legislative history supports the Ninth Circuit's reasoning. The court cannot rewrite the statute to lessen its administrative burden. When the statute says we must pay hospitals on the basis of their economy and efficiency, we cannot limit our inquiry solely to in-state hospitals. When the statute says we must obtain cost reports and do audits, again, we cannot limit those provisions to in-state facilities if the Boren Amendment truly applies to out-of-state facilities.

As we have noted, Boren requires a state to pay at a rate based on costs which must be incurred by "efficiently and economically-operated facilities." How do we determine whether the bill submitted to us by an out-of-state hospital represents costs which meet these criteria? We cannot simply accept the assurance of the billing hospital that its facility is operated efficiently and economically. In order for us to pay only what is necessary, we must obtain data which will enable us to make an informed decision. We must obtain the

hospital's cost reports. We must do an audit. We must obtain comparative data for other hospitals in that geographical area. We must determine whether it is a DSH hospital, whether it provides adequate access for poor people, etc.

It is illogical to conclude that Congress intended that these determinations be made for every hospital in every state where a hospital treats an out-of-state Medicaid patient. Again, a hypothetical illustrates the point. Suppose a high school reunion takes place in a town in North Dakota. The attendees are being bused to a function. The bus goes off the road and 40 people are injured. They are taken to a local hospital. Assume that 10 of the 40 are eligible for Medicaid assistance in their home state. If the Boren Amendment were to apply and its literal terms observed, each of the 10 states would have to make a determination whether, in their individual respective judgments, the bills sent by the North Dakota hospital represented costs which were required to be incurred by an efficient and economically run hospital. Each state would thus be required to obtain cost data from the hospital, conduct an audit, and make the other determinations described above. This would put a huge burden on each state and a truly hideous burden on the subject hospital. We cannot believe this was intended by Congress. We should also add that if indeed it was not intended, the courts cannot alter the statute to make the procedure less cumbersome.

Our position on this issue was buttressed by the amicus brief filed by HCFA. That brief provides a further explanation of the insurmountable difficulties a state would face in trying to apply the Boren Amendment's reasonable and adequate payment provisions to out-of-state hospitals. HCFA noted in its brief that it is,

> " ... virtually impossible for States to comply with the Boren Amendment with respect to out-of-state providers. It is not possible for California, or any other state, to anticipate, for purposes of establishing payment rates for out-of -state providers, and for making the required findings and assurances with respect to payment rates...." (Emphasis added).

HCFA further stated,

> "Medi-Cal eligible California residents could theoretically receive out-of-state care in only a few out-of-state hospitals in a handful of states, or in countless hospitals in every state in the country."

As we have observed, Congress intended the Boren Amendment's cost reporting and auditing provision to apply only to in-state hospitals. This is consistent with the view that Congress intended for states to use the data obtained from in-state cost reports and audits of those reports to make findings as to whether payments are reasonable and adequate to meet the costs of efficiently and economically operated hospitals.

As HCFA also noted,

> "It is also not possible for a State to project, for purposes of making the required findings and assurances on a prospective basis, what costs must be incurred by an efficiently and economically operated out-of-state facility to provide care and services in conformity with applicable State and Federal 'laws, regulations, and quality and safety standards.' A state's access to the data necessary to determine whether an out-of-state provider is efficiently and economically operated and whether the

> costs incurred by a particular out-of-state provider that has treated a state's residents are costs that 'must be incurred' in providing care in conformity with the quality and safety standards and State applicable regulations, is necessarily limited."

A state's ability to make findings as to what payments would be reasonable and adequate to meet the costs of efficiently and economically operated out-of-state hospitals is further hampered by the lack of knowledge of out-of-state licensure laws. These laws vary widely from state to state and significantly impact staffing levels, qualifications, equipment, and technology which must be available to treat patients in that state. As HCFA correctly pointed out,

> "California would not likely have access to information regarding occupancy rates in the provider's home state, and thus, would not be able to determine whether the facility operated 'efficiently and economically.'"

We reiterate that the court below should have deferred to the views of the federal agency. In any event, our point is that the difficulties of applying Boren to out-of-state hospitals are manifest and the Ninth Circuit had no authority to rewrite the statute to eliminate or mitigate those problems.

CONCLUSION

This Court should grant the writ to a) safeguard the principle that a case is moot in the absence of a justiciable controversy; b) reassert the rule that a court cannot violate the separation of powers doctrine by reviving a repealed statute; and c) confirm the principle

that a court should defer to the views of the agency charged with administering a statute.

Finally the Ninth Circuit's conclusion that the Boren Amendment applies to out-of-state hospitals is plainly wrong and should be rectified lest it create a damaging precedent for programs across the entire country.

Dated: March 2, 2000.

Respectfully submitted,

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CHILDREN'S HOSPITAL AND HEALTH CENTER, a Washington corporation;	)	
Plaintiff-Appellee,	)	**No. 98-15559**
v.	)	**D.C. No.**
S. KIMBERLY BELSHE, Director, California Department of Health Services,	)	**CV-95-01076-MHP**
Defendant-Appellant.	)	

Appeal from the United States District Court
for the Northern District of California
Marilyn Hall Patel, District Judge, Presiding

Argued and Submitted
June 15, 1999-San Francisco, California

Filed August 16, 1999

Before: Joseph T. Sneed, David R. Thompson
and William A. Fletcher, Circuit Judges.

Opinion by Judge Thompson; Dissent by Judge Sneed

SUMMARY

Health/Medicaid/MediCare and Government Assistance

The court of appeals affirmed a judgment of the district court. The court held that states must meet the requirements of the Boren Amendment provisions of the Medicaid Act in setting

reimbursement rates for out-of-state hospitals that treat their Medicaid patients.

States wishing to receive Medicaid funds from the federal government must submit a medical assistance plan to the Secretary of Health and Human Services detailing coverage and the methodology to be used in reimbursing institutional health-care providers for services rendered to Medicaid recipients. The Boren Amendment to the Medicaid Act requires state plans to include reimbursement standards and methodologies that meet three criteria: states must make additional (DSH) payments to hospitals serving a disproportionate share of low-income patients; make findings that the rates are "reasonable and adequate" to meet necessary cost of an efficiently run hospital; and assure Medicaid patients reasonable access to inpatient care.

Appellee Children's Hospital and Health Care and other hospitals outside California that provided services to the State's Medicaid (Medi-Cal) patients sued appellant Kimberly Belshe, Director of the California Department of Health Services (CDHS), for a declaratory and injunction relief. They alleged that CDHS was violating the Boren Amendment by failing to make the required findings for payments to out-of-state hospitals, and by failing to make DSH payments to hospitals that were entitled to them.

CDHS moved for summary judgment on the ground that the Boren Amendment does not apply to out-of-state hospitals. On January 9, the district court denied the motion, ruling that the Boren Amendment applies to out-of-state hospitals.

Soon after the district court issued its order, Congress enacted the Balanced Budget Act of 1997 (BBA), which amended the Medicaid Act to eliminate the Boren Amendment. The new section continued to require that states take into account hospitals that serve a disproportionate number of low-income patients, but repealed the "findings" and "assurances" provisions of the Boren Amendment, and substituted a "public process," i.e., notice-and-comment, provision. It became effective with respect to payments for services commencing October 1, 1997.

The Health Care financing Administration (HCFA) advised Medicaid-participating states that compliance with the public process requirements would be waived for payment methodologies that were validly determined under the Boren Amendment.

Based on the HCFA notice, CDHS continued to administer the Medi-Cal program by using Boren Amendment payment methodology. However, CDHS refused to apply that methodology to reimbursement to out-of-state hospitals for services provided to Medi-Cal patients.

In a second order on February 4, 1998, the district court determined that the CDHS's method for reimbursing out-of-state hospitals did not satisfy the Boren Amendment's "findings" requirement, i.e., that until CDHS developed new rates for payment under the "public process" provisions of the BBA, it had to comply with the Boren Amendment. The court certified for interlocutory appeal the question of whether the Boren Amendment applied to out-of-state hospitals, and stayed the action pending a decision by the court of appeals.

Belshe contended that the appeal should be dismissed and the district court's orders vacated because the repeal of the Boren Amendment mooted any prospective relief. The Director also asserted that the court of appeals should defer to the HCFA's determination that the Boren Amendment does not apply to out-of-state hospitals. Finally, CDHS complained that applying the Boren Amendment to out-of-state hospitals would impose too great an administrative burden on the states.

[1] A live controversy existed in this case, and the court of appeals could grant effective relief. [2] The action was not mooted by the repeal of the Boren Amendment. [3] Nor was the suit foreclosed by the Eleventh Amendment. Although the Eleventh Amendment precludes an action against state officers to recover past-due payments, it does not preclude a suit for prospective relief from an ongoing violation of federal law. CDHS was committing an ongoing violation of federal law if the Boren Amendment applies to out-of-state hospitals.

[4]In setting forth reimbursement requirements, the Boren Amendment refers to "hospital services" without limiting such

services to those provided by in-state hospitals. Because the statute does not distinguish between in-state and out-of-state hospitals, the plain meaning of the statute is that Congress did not intend to differentiate between the two. [5] This interpretation was buttressed by the fact that elsewhere in the Medicaid statute Congress created distinctions for in-state institutions.

[6] The court of appeals could not defer to the HCFA's interpretation of the Boren Amendment where Congress has unambiguously addressed the issue.

[7] Belshe failed to identify any statements by Congress that applying the Boren Amendment to out-of-state hospitals was too burdensome on the states. Moreover, if Congress was concerned about the administrative burden imposed by applying the Boren Amendment to out-of-state providers, it would have added the words "in-state" to the "hospital services" language of the Amendment, instead of repealing it.

[8] A state need not use the same rate-setting scheme for non-participating out-of-state hospitals as it does for in-state hospitals. Although the administrative burden on states reimbursing out-of-state providers might be significant, those does not provide evidence that Congress did not intend to apply the Boren Amendment's requirements to out-of-state hospitals.

Judge Sneed dissented on the ground that the Boren Amendment does not apply to out-of-state hospitals.

COUNSEL

Asher Rubin, Deputy Attorney General, San Francisco, California for the defendant-appellant.

Michael S. Sorgen, San Francisco, California, for the plaintiff-appellee.

OPINION

THOMPSON, Circuit Judge:

OVERVIEW

Eighteen hospitals located outside of California ("the plaintiffs") brought suit against S. Kimberly Belshe ("Belshe"), Director of the California Department of Health Services ("CDHS"). The plaintiffs alleged that CDHS's method for reimbursing out-of-state hospitals that treat California's Medicaid ("Medi-Cal") patients violates the portion of the Social Security Act known as the Boren Amendment, 42 U.S.C.A. U 1396a(a)(13)(A)(West 1992). Belshe moved for summary judgment.

In its first summary judgment order, the district court held the Boren Amendment applies to out-of-state hospitals. Thereafter, in a second order, the district court held the CDHS was failing to meet the Boren Amendment's requirements in setting reimbursement rates for out-of-state hospitals that treat Medi-Cal patients. The court also held the CDHS is obligated to make additional payments to out-of-state hospitals treating Medi-Cal patients that serve a disproportionate share of low-income individuals ("DSH payments"). The district court then certified its summary judgment orders for immediate appeal pursuant to 28 U.S.C. § 1292(b), and this appeal followed.

In this appeal, Belshe argues the plaintiffs' lawsuit is moot because the Boren Amendment was repealed during the pendency of the action, and in any event, the lawsuit is barred by the Eleventh Amendment. Alternatively, Belshe contends that the district court erred in holding that the Boren Amendment applies to out-of-state hospitals. We have jurisdiction under 28 U.S.C. § 1292(b), and we affirm.

BACKGROUND

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq. ("the Medicaid Act"), authorizes the payment of federal funds to states to defray expenses incurred in providing medical assistance to low-income individuals. *See* 42 U.S.C. § 1396; *Wilder v. Virginia Hosp. Ass'n.* 496 U.S. 498, 502 (1990). Unlike Medicare, which is administered nationally, the Medicaid Act is administered by the individual states that choose to participate in the program. If a state participates in the program, the state must comply with the requirements of the Medicaid Act and its implementing regulations. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 430 et seq.; *Wilder*, 496 U.S. at 502. All fifty states have chosen to participate.

States wishing to receive Medicaid funds must submit a state medical assistance plan to the Secretary of Health and Human Services ("Secretary"). This plan must detail the state's coverage and include the methodology it will use to reimburse institutional health care providers for the services they render to Medicaid recipients. *See* 42 U.S.C. § 1396a(a); 42 C.F.R. §§ 430.10-430.18; *Wilder*, 496 U.S. at 502. The plan must be approved by the Health Care Financing Administration ("HCFA"), the federal agency responsible for administering the Medicaid program. *See* 42 C.F.R. §§ 430.10, 420.12.

Prior to 1980, states were required to reimburse hospitals the "reasonable cost" of providing inpatient services, generally in the form of retrospective payments based on a hospital's actual costs for given services. *See* 42 U.S.C. § 1396a(a)(13)(1976); *Folden v. Washington State Dep't of Social and Health Serv.*, 981 F.2d 1054, 1056 (9th Cir. 1992). Hoping to contain escalating medical costs, Congress enacted a new standard for hospital reimbursement as part of the 1981 Omnibus Reconciliation Act, Pub.L.No. 97-35 § 2173. This new standard, known as the Boren Amendment, required a state plan to

> provide ... for payment ... of the hospital services ... provided under the plan through the use of rates (determined in accordance with methods and standards

> developed by the State ... and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital ... and periodic audits by the State of such report....

42 U.S.C.A. § 1396A(A)(13)(a) (West 1992).

The purpose of the Boren Amendment was "to give states greater flexibility in calculating reasonable costs and in containing the continuing escalation of those costs." *Folden*, 981 F.2d at 1056. The Third Circuit in *West Virginia University Hospital, Inc. v. Casey* 885 F.2d 11 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991), concluded that the Boren Amendment "authorizes state to develop their own medicaid reimbursement standards and methodologies to three general federal requirements." *Id.* at 22. First, states must take into account hospitals serving a disproportionate share of low-income patients. *Id.* at 22-23. Second, states must make findings that the rates are "reasonable and adequate" to meet the necessary costs of an efficiently operated hospital. *Id.* And third, states must assure Medicaid patient reasonable access to inpatient hospital care. *Id.* As the Third Circuit noted in *West Virginia University Hospital*, these requirements are set forth in 42 C.F.R. §§ 447.250-447.280. *Id.*

The plaintiffs in this case, eighteen hospitals outside of California that provided services to Medi-Cal patients, filed suit on March 28, 1995 for declaratory and injunctive relief. They allege that Belshe, the Director of the CDHS, is violating the Boren Amendment by failing to make the Amendment's required findings for payments to out-of-state hospitals and by failing to make DSH payments to out-of-state hospitals serving a disproportionate share of low-income individuals.[1] Belshe moved for summary judgment, arguing that the Boren Amendment does not apply to out-of-state hospitals. On January 9, 1997, the district court denied the motion, holding that the Amendment applies to out-of-state hospitals.

Soon after the district court issued its January 9, 1997 order, Congress amended the Medicaid Act to "eliminate the Boren Amendment and establish instead a notice and comment provision." *Exeter Memorial Hosp. Ass'n v. Belshe*, 145 F.3d 1106, 1108 (9th Cir. 1998) (citing Balanced Budget Act of 1997, Pub.L.No. 105-33, 111 Stat. 251, § 4711, codified at 42 U.S.C. § 1396a(a)(13)(A)). The new section became effective with respect to payments for services commencing October 1, 1997. *See id.* The new section continues to require that states take into account hospitals that serve a disproportionate number of low-income patients, but repeals the "findings" and "assurances" methodology enumerated in the Boren Amendment. Instead, the new section requires a "public process" for determining rates.[2]

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1. The CDHS uses Boren Amendment standards in determining the methodology for reimbursing in-state hospitals, ninety percent of which are paid for inpatient services at a negotiated contract rate and some of which receive additional payments ("DSH payments") for serving a disproportionate share of low-income patients. By contrast, Belshe admits that the CDHS pays out-of-state hospitals "at the average of the contract rates paid to California hospitals" and does not make any DSH payments to out-of-state hospitals.

2. The new section of the statute requires that a state plan for medical assistance

(13) provide-

After the Boren Amendment was repealed, the district court held in a second order on February 4, 1998, that the CDHS's method for reimbursing out-of-state hospitals did not satisfy the findings required by the Boren Amendment. In essence, the district court held that until the CDHS developed new rates for payment pursuant to the "public process" provisions of the Balanced Budget Act of 1997, the CDHS had to comply with the Boren Amendment. The court also held that the Amendment required the CDHS to make DSH payments to out-of-state hospitals. Concluding that its determinations about the applicability of the Boren Amendment to out-of-state hospitals involved a "controlling question of law as to which there may be substantial ground for difference of opinion," the district court certified the question for interlocutory appeal, which appeal this court authorized pursuant to 28 U.S.C. § 1292(b). The district court then stayed the action pending our decision in this appeal.

> (A) for a public process for determination of rates of payment under the plan for hospital services ... under which-
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed are published,
>
> (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
>
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
>
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;
>
> ....

42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1998).

DISCUSSION

A. Mootness and Eleventh Amendment Immunity

[1] Belshe contends this appeal should be dismissed and the district court's orders vacated because the repeal of the Boren Amendment renders any prospective relief moot. We disagree. A live controversy exists in this case, *see Cook Inlet Treaty Tribes v. Shalala*, 166 F.3d 986, 989 (9th Cir. 1999), and we can grant effective relief. *Cf. Calderon v. Moore*, 518 U.S. 149, 150 (1996) (an appeal should be dismissed as moot "when, by virtue of an intervening event, a court of appeals cannot grant 'any effectual relief whatever'...." (citation omitted)).

After the Boren Amendment was repealed, HCFA advised its regional offices and the states participating in the Medicaid program that compliance with the new public process requirements of 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1998) (the section that replaced the Boren Amendment) would be waived for payment methodologies that had been validly determined under the Boren Amendment. *See* December 10, 1997 Letter from HCFA to State Medicaid Director ("In other words, states are not required to subject their existing rates to a public process to the extent that those existing rates were validly determined in accordance with legal standards in effect prior to October 1, 1997."). This letter from HCFA authorized states to continue to use payment methodologies approved under the Boren Amendment standard notwithstanding its repeal. Pursuant to this letter authority, CDHS continues to administer its Medi-Cal program by using the Boren Amendment payment methodology. It refuses, however, to apply that methodology to its reimbursement of out-of-state hospitals for services they provide to Medi-Cal patients. The plaintiffs ask us to declare this exclusionary practice unlawful and to enjoin the CDHS from continuing it.

[2] Because a live controversy exists and we can grant effective relief, we conclude this action is not mooted by the repeal of the Boren Amendment. *Cf. Exeter Memorial Hosp. Ass'n v.*

Belshe, 145 F.3d 1109, 1108-09 (9th Cir. 1998) (noting the repeal of the Boren Amendment after the district court's decision, yet holding, without expressing concerns about mootness, that the CDHS violated the Boren Amendment when it implemented changes to its Medicaid plan without first obtaining federal approval).

[3] Nor is the plaintiffs' suit foreclosed by the Eleventh Amendment. Although the Eleventh Amendment precludes any action against state officers to recover past due payments, it does not preclude a suit against state officers for prospective relief from an ongoing violation of federal law. *See Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 288 (1997) (O'Connor, J., concurring); *Ex parte Young*, 209 U.S. 123; 159-60 (1908). Here, the CDHS continues to administer its Medicaid program pursuant to the Boren Amendment, but denies reimbursement to out-of-state hospitals that provide services to Medi-Cal patients. In pursuing this course of action, the CDHS is committing an ongoing violation of federal law if the Boren Amendment applies to out-of-state hospitals.[3]

B. Application of the Boren Amendment to Out-of-State Hospitals

For services rendered to Medi-Cal patients, California reimburses its in-state hospitals differently from the way it reimburses out-of-state hospitals. Belshe argues the Boren Amendment permits this because Congress intended to limit payments under Boren to in-state hospitals, and applying Boren's

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3. *Green v. Mansour*, 474 U.S. 64 (1985), on which the CDHS relies, is inapposite. There, the state brought its policy into compliance with a newly enacted federal law while the case was pending in the district court. *Id.* at 66. Here, although the Boren Amendment was repealed while this case was pending in the district court, the CDHS continues to operate under the Amendment and has not changed its policy of denying reimbursement to out-of-state hospitals that provide services to Medi-Cal patients; nor has it developed new rates for payment pursuant to the "public process" provisions of the Balanced Budget Act of 1997.

requirements to out-of-state hospitals would impose a large, unintended administrative burden on the states. We reject Belshe's legislative intent argument because it runs counter to the plain meaning of the Boren Amendment and the statute's legislative history. We reject Belshe's administrative burden argument because we find it unpersuasive.

1. Legislative Intent

a. Plain Meaning

Statutory interpretation begins with the language of the statute. *See United States v. Ron Enters., Inc.*, 489 U.S. 235, 241 (1989). When the plain meaning of a statutory provision is unambiguous, that meaning is controlling. *Id.* at 242. To determine the plain meaning of a statutory provision, we examine not only the specific provision at issue, but also the structure of the statute as a whole, including its object and policy. *See Green v. Commissioner*, 707 F.2d 404, 405 (9th Cir. 1983). If ambiguity exists, we may use legislative history as an aid to interpretation. *See id.; Mt. Graham Red Squirrel v. Madigan*, 954 F.2d 1441, 1453 (9th Cir. 1992).

[4] In setting forth the reimbursement requirements, the text of the Boren Amendment refers to "hospital services," without limiting such services to those provided by in-state hospitals. 42 U.S.C.A. § 1396a(a)(13)(A) (West 1992). Belshe argues that Congress's failure to refer to out-of-state hospitals in the Amendment points to Congress's intent to exclude them. We disagree. In fact, it is the converse of this argument that is persuasive. Because the statute does not distinguish between in-state and out-of-state hospitals, the plain meaning of the statute is that Congress did not intend to differentiate between the two.

[5] This interpretation is buttressed by the fact that elsewhere in the Medicaid statute (though not in the Boren Amendment) Congress creates distinctions for in-state institutions. For example, when a state plan includes medical assistance for services in an intermediate care facility for the mentally retarded,

Congress requires periodic on-site inspections of each such facility "within the state." 42 U.S.C.A. § 1396(a)(31)(B) (West 1992).

Belshe refers to the definitions section of the Medicaid statute, 42 U.S.C. § 1396r-4(b)(1)(A), which sets forth the requirements for a hospital to be eligible for DSH payments. That section defines hospitals eligible for DSH payments by comparing them to the mean of "hospitals receiving medicaid payments in the State." Belshe argues this language proves that the DSH payment requirement in the Boren Amendment applies only to in-state hospitals. This argument fails.

Section 1396r-4(b)(1)(A) provides that states administering their Medicaid programs are required to determine whether a hospital qualifies for DSH payments by referring to the mean number of Medicaid patients served by hospitals in their state. This language does not say that only hospitals within the state can qualify for DSH payments; instead, it uses in-state hospitals to calculate a benchmark for the number of Medicaid patients served to determine whether a hospital (in-state or out-of-state) qualifies for DSH payments. Hospitals serving a number of Medicaid patients "at least one standard deviation above the mean" qualify as DSH hospitals. 42 U.S.C. § 1396r-4(b)(1)(A). Thus, for example, a hospital in Arizona serving a number of Medicaid patients one standard deviation above the mean of hospitals serving Medicaid patients in California would meet this criterion for qualification, and could therefore seek DSH payments from California for treating MediCal patients. Or, alternately, an Arizona hospital qualifying for DSH payments under the Arizona Medicaid program because of comparison with the mean of Arizona hospitals would similarly meet this criterion.

No court, other than the district court in this case, has directly interpreted the language of the Boren Amendment with regard to its applicability to out-of-state hospitals. Two courts have concluded by implication, however, that the Boren Amendment applies to out-of-state hospitals. In *West Virginia University Hospital, supra*, 885 F.2d at 29, the Third Circuit concluded that Pennsylvania's reimbursement rate for a nearby West Virginia hospital that served many Pennsylvania Medicaid patients violated

the requirements of the Boren Amendment. The court scrutinized the statutory language for its relevance to out-of-state hospitals:

> Nothing in section 1396(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines; it nowhere suggests that state boundary lines act as points of demarcation in reimbursement for the delivery of healthcare. Under the federal regulations ... state boundary lines, except for administrative responsibility, bear an insignificant role, if any, with respect to the actual delivery of health care in a program designed on a national level to aid the poor in a highly mobile society.

Id.

In addition, a district court in this circuit has concluded by implication that the Boren Amendment applies to out-of-state hospitals. *See Multicare Medical Center v. Washington*, 768 F.Supp. 1349, 1401 (W.D. Wash. 1991) (holding that Washington must make DSH payments to out-of-state border hospitals that serve Washington's Medicaid recipients). These court decisions, while not directly on point, lend support to our conclusion that the Boren Amendment unambiguously applies to out-of-state hospitals.

b. Legislative History

Because the Boren Amendment is unambiguous, we need not examine its legislative history. *See Green*, 707 F.2d at 405. Nevertheless, given the importance of the issue and the ,present view of the Secretary and HCFA, we shall examine the statute's legislative history. *See id.* at 407.

Congress passed the Boren Amendment "to give states greater flexibility in calculating reasonable costs and in containing the continuing escalation of those costs." *Folden*, 981 F.2d at 1056. The Senate Report comments that, under the Boren Amendment, "[s]tates would be free to establish rates on a statewide or other geographic basis, without reference to medicare principles of

reimbursement." S. Rep. No. 97-139, 97th Cong., 1st Sess. 478, *reprinted in* 1981 U.S. Code Cong. & Admin. News 744. As the district court correctly observed, this statement suggests that Congress was not assuming rates would be set under the Boren Amendment according to state boundaries.

The Senate Report also states that "[t]he flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." *Id.* This statement demonstrates Congress's underlying concern for maintaining quality health care, a goal which would be compromised if states could reduce their rates arbitrarily. Congress was also attentive to the broad purpose of the entire Medicaid program, which was to provide health care to low income individuals. *See West Virginia Univ. Hosp.*, 885 F.2d at 23 (explaining that the states' discretion was limited by Congress's desire to ensure that Medicaid recipients have access to services and that disproportionate share hospitals are not discouraged from providing care to Medicaid patients due to inadequate financial support).

As the district court wisely concluded, "[i]nasmuch as the Boren Amendment was a sophisticated attempt to fulfill [the goal of quality care] while at the same time encouraging efficiency, it makes little sense to remove out-of-state hospitals from that worthy rubric."

[6] Belshe asks us to defer to HCFA's current interpretation of the Boren Amendment, which interpretation it propounded in an *amicus curiae* brief filed in the district court. In that brief, HCFA took the position that the Boren Amendment does not apply to out-of-state hospitals. We reject Belshe's request. We may not defer to HCFA's interpretation where Congress has unambiguously addressed the issue. *See Chevron, U.S.A., Inc. v. N.R.D.C., Inc.*, 467 U.S. 837, 843 (1984).

2. Administrative Burden

[7] Belshe also argues.that applying the Boren Amendment to out-of-state-hospitals would impose too high an administrative burden on the states. This argument relates to Congress's intent in

enacting, and then repealing, the Boren Amendment. Belshe contends that the repeal of the Boren Amendment and its replacement with a simpler public notice and comment requirement is evidence that Congress thought applying the Boren Amendment to out-of-state hospitals was too burdensome on the states. We reject this argument. Belshe fails to identify any statements by Congress raising the concerns she cites. Moreover, common sense dictates that, if Congress were concerned about the administrative burden imposed on the states by applying the Boren Amendment to out-of-state providers, instead of repealing the Amendment, it would simply have added the words "in-state" to the "hospital services" language of the Amendment. Congress's actions, therefore, do not imply that the Amendment's -repeal was prompted by a concern for the burden of complying with the Amendment's provisions for payments to out-of-state hospitals.

Nevertheless, Belshe argues Congress must have meant to exclude out-of-state hospitals from the Amendment because it would be impossible for a state to anticipate, and establish reimbursement rates for, all out-of-state hospitals where its Medicaid patients might receive care. Compounding the difficulty, Belshe argues, would be the necessity of determining whether the operational costs incurred by out-of-state facilities meet the "efficiently and economically operated facility" standard of the Boren Amendment.

The weakness in Belshe's argument is that she presumes the Boren Amendment requires states to apply the same methodology and administrative requirements to out-of-state hospitals that states apply to in-state hospitals. This is not so. As the Third Circuit noted in West Virginia University Hospital, "[w]e neither hold nor suggest that Pennsylvania must apply precisely the same methodology to ... out-of-state hospitals as it does for its in-state hospitals if there is a rational basis for departure." 885 F.2d at 29. The key is that "[tlhe methodology applied ... be rational, not arbitrary or whimsical." *Id.*

In the case of out-of-state hospitals providing only occasional emergency care, a state could develop a reasonable methodology for reimbursement different from its in-state provider

methodology. Indeed, as the district court observed, some of the impracticalities Belshe cites would not necessarily apply to out-of-state hospitals. For example, many of the regulations Belshe cites as being too difficult to apply, such as uniform cost reporting and period audits, apply only to "participating providers," which are hospitals enrolled in a state's Medicaid program. See 42 C.F.R. § 447.253(g). An out-of-state hospital might not be-enrolled in such a program, although it could be. As the district court noted in reviewing the State of Georgia's administration of its Medicaid program, some out-of-state hospitals are enrolled in Georgia's Medicaid program and Georgia reimburses these hospitals at the same rates it uses to reimburse in-state, enrolled hospitals. With regard to non-enrolled out-of-state hospital s, however, Georgia reimburses them at rates consistent with the other state's rates under the Medicaid program or at a specified percentage of allowable costs.

[8] In sum, although the Boren Amendment has extensive reimbursement requirements, a factor that may well explain why Congress chose in 1997 to repeal it, the Amendment nonetheless permits states some flexibility in developing their reimbursement methodologies. We conclude, as did the Third Circuit in West Virginia University Hospital, that a state need not use the same rate-setting scheme for non-participating out-of-state hospitals as it does for in-state hospitals. Although the administrative burden on states in reimbursing out-of-state providers under the Boren Amendment may still be significant, this burden does not provide evidence that Congress did not intend to apply the Amendment's requirements to out-of-state hospitals.

CONCLUSION

Even though Congress repealed the Boren Amendment during the pendency of this action, the case is neither moot nor barred by the Eleventh Amendment. The CDHS has the option of complying with the Boren Amendment or with the public process provisions of the Balanced Budget Amendment of 1997. It does not have the option of failing to comply with either law. So long as

it fails to comply with the Balanced Budget Amendment, it is bound by the Boren Amendment, and we hold that the Boren Amendment applies to all hospitals, including out-of-state hospitals. We reject Belshe's contention that the administrative burden of applying the Amendment to out-of-state providers suggests that Congress intended otherwise.

AFFIRMED.

SNEED, J., Dissenting:

I respectfully dissent.

In this case, we are asked to decide whether the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A) (1997), applies to out-of-State providers, including appellees Children's Hospital and Medical Center, et al. ("appellees"). I conclude that it does not.

Although I agree with the majority that appellees present a live controversy in this case that we can properly review, I disagree with the majority's statutory analysis of the Boren Amendment and its decision to disregard HCVA's interpretation of it. The majority improperly concludes that the Boren Amendment is unambiguous. In so doing, it ignores the reasonable interpretation of a statute proposed by the administrative agency charged by Congress to implement it. This, of course, ignores the teaching of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837,- 843, 104 S. Ct. 2778, 2782, 81 L. Ed. 2d 694 (1984).

The Boren Amendment is ambiguous and HCVA's interpretation of the statute is permissible. Therefore, I would reverse the decision-of the district court.

This case involves a complex administrative and statutory scheme. Consequently, an overview of the process by which states reimburse providers of medical services rendered to people who qualify for Medicaid assistance is necessary.

Medicaid is a joint federal-state program that provides "federal financial assistance to States that choose to reimburse

certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301, 100 S.Ct. 2671, 2677-78, 65 L.Ed.2d 784 (1980). Although the federal government provides guidelines that the participating states must follow before they are eligible for reimbursement, each of those states enjoys great flexibility in carrying out the Medicaid program. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502, 110, S.Ct. 2510, 2512-13, 110 L.Ed.2d 455 (1990), *rev'd Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360, 118 L.Ed.2d 1 (1992). A participating state must, for example, provide the federal government with a plan to provide medical assistance to qualified individuals and a methodology to reimburse providers of such services. See 42 U.S.C. § 1396a (1997). The state, however, is free to develop its program in the way it sees fit; in other words, it must only follow general federal guidelines. One such guideline-the Boren Amendment-is the subject of this appeal.

Congress enacted 42 U.S.C. § 1396a(a)(13)(A), commonly known as the Boren Amendment, in 1980. *See Folden v. Washington State Dep't of Social and Health Serv.*, 981 F.2d 1054, 1056 (9th Cir. 1992). The Boren Amendment provided, in pertinent part, that a state plan for medical assistance must:

> provide ... for payment ... of the hospital services ... provided under the plan through the use of rates (determined in accordance with the methods and standards developed by the State ... and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes

> further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital ... and periodic audits by the State of such reports....

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

The majority quite correctly points out that Congress' purpose in enacting the Boren Amendment was "to give states greater flexibility in calculating reasonable costs and in containing the continuing escalation of those costs." Maj. Op. at 9175 (quoting *Folden*, 981 F.2d at 1056). Prior to its enactment, the Boren Amendment required the states to submit more detailed schemes describing methods for reimbursement which the federal government had to approve as "reasonable." *See Folden*, 981 F.2d at 1056 (citing 42 U.S.C. § 1396a(a)(13)(E)(1976)). In an attempt to provide participating states with greater flexibility, the Boren Amendment "authorize[d] states to develop their own medicaid reimbursement standards and methodologies for payment of hospital services." *West Virginia Univ. Hosp., Inc. v. Casey*, 885 F.2d 11, 22 (3rd Cir. 1989), *aff'd on other grounds* 499 U.S. 83, 111 S.Ct. 1138, 113 L.Ed.2d 68 (1991). Under the Code of Federal Regulations, these standards and methodologies only needed to follow three general guidelines: (1) to specially consider those hospitals serving a disproportionate share of low income individuals, 42 C.F.R. § 447.298; (2) to make findings that their rates were reasonable and adequate, 42 C.F.R. § 447.252(b); and (3) to assure reasonable access to inpatient hospital care, 42 C.F.R. § 447.256. By enacting the Boren Amendment, Congress intended to require only "the minimum level [of oversight] necessary to assure proper accountability, and not to burden States and facilities with unnecessary paperwork requirements." 48 Fed.Reg. 56,047.

HCVA, in its attempt to carry out this congressional intent (i.e., to allow states to develop their own programs to meet the needs of Medicaid patients), did not provide specific criteria for states to follow when determining "reasonable and adequate" rates under 42 U.S.C. § 1396. Nor did HCVA verify the proposed

"findings" provided by the States under the statute; instead, HCVA examined only the assurances submitted to determine if they were "adequate." See, e.g., 42 C.F.R. §§ 447.298, 447.252(b), 447.256. In other words, the federal government, under the Boren Amendment, left to the states the bulk of the decisions relating to Medicaid disbursements. According to HCVA, at the time appellees brought suit in 1995, in the decade-and-a-half that the Boren Amendment existed, *no state plan, including those plans that did not provide for out-of-state reimbursement, was ever rejected* for failure to comply with the Amendment's strictures.

The Boren Amendment, however, did impose some requirements on state Medicaid programs. For example, the Amendment required each state to make "findings" that such payments as they did make to *each* hospital for all services rendered to Medicaid-eligible patients was no more than what would have been charged by an "efficiently" and "economically" operated institution. *See, e.g.*, 42 C.F.R. 447.252(b). According to HCVA, this was a provider-specific determination. Thus, even if an out-of-state facility only provided services to one California Medicaid patient, California, upon receiving a bill for services rendered, was required to audit that institution to determine whether the rate charged by the facility was reasonable.

Congress in 1997 apparently decided that the Boren Amendment had become too cumbersome for states to follow. *See Exeter Memorial Hosp. Ass'n v. Belshe*, 145 F.3d 1106, 1108 (9th Cir. 1998). As of October 1, 1997, the Boren Amendment was repealed and replaced with a "public process" statute to determine rates for Medicaid reimbursement and eliminated the "findings" and "assurances" provision contained within the Boren Amendment. *See* 42 U.S.C. § 1396a(a)(13)(A)(1998). Notwithstanding the Boren Amendment's repeal, HCVA distributed a letter to state Medicaid agencies, informing them that, until such time that they switched to the "public process" method of reimbursement, they could continue to operate under the Boren rubric. California has not yet implemented a Medicaid program to comply with the new "public process" method and

continues to make payments to Medicaid patients pursuant to the guidelines set forth in the Boren Amendment.

II

This case raises only one issue: Does the Boren Amendment apply to out-of-state providers? We first look to the language of the Boren Amendment for the answer to this question. *See Queen of Angels/Hollywood Presbyterian Med Ctr. v. Shalala*, 65 F.3d 1472, 1477 (9th Cir. 1995). It states, in pertinent part, that a state plan for medical assistance must:

> provide ... for payment ... of the hospital services ... provided under the plan through the use of rates (determined in accordance with the methods and standards developed by the State ... and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital ... and periodic audits by the State of such reports....

42 U.S.C. § 1396a(a)(13)(A).

Specifically, the issue before us is the scope of the phrase "hospital services." Appellees contend that "hospital services" refers to both in-state and out-of-state providers, whereas appellants

argue that "hospital services" refers only to in-state providers. The majority concludes that "[b]ecause the statute does not distinguish between in-state and out-of-state hospitals, the plain meaning of the statute is that Congress did not intend to differentiate between the two." Maj. Op. at 9181. In essence, the majority's position rests on a negative inference. It argues that because Congress did not specifically state that Boren applies to only in-state hospitals, it must have intended that the statute applies to both in-state and out-of-state hospitals. I disagree.

Admittedly, neither party presents strong evidence to support its respective "plain language" interpretation of the Boren Amendment. Appellant, for example, relies on another provision of the Medicaid statute, 42 U.S.C. § 1396r-4(b)(1)(A), which sets forth the requirements that a hospital must meet to be considered a disproportionate share hospital for purposes of the Boren Amendment. The statute states that a hospital will qualify as a disproportionate share hospital only if it compares favorably to the mean of "hospitals receiving medicaid payments *in the State*." 42 U.S.C. § 1396r-4(b)(1)(A) (1998) (emphasis added). This language, appellant contends, demonstrates that the Boren Amendment applies only to in-state hospitals.

This argument overlooks the fact that § 1396r-4(b)(1)(A) does not refer to the scope of the Boren Amendment. Its purpose is to determine whether an "in-state" hospital qualifies as a disproportionate share hospital. That is, it requires a state to calculate whether a hospital has a certain percentage of Medicaid patients relative to other hospitals "in the State." It does not refer to reimbursement procedures; instead, it sets forth the method by which a state is to determine if a hospital within the state cares for a sufficient number of Medicaid patients to qualify for status as a disproportionate share hospital.

Appellees, on the other hand, contend that, because the statute does not distinguish between in-state and out-of-state hospitals, it is clear that Congress did not intend to differentiate between the two. The majority accepts this contention. Thus, the failure of Congress to delineate the boundaries of the Boren Amendment is said to warrant the conclusion that the Boren

Amendment applies to all hospitals in the United States. I disagree.

The statute is ambiguous. It follows that to determine the scope of the phrase "hospital services" we must consider both the legislative intent behind the enactment of the statute and any "reasonable interpretation" proffered by HCVA, the implementing agency.

III.

Because the "plain language" fails to provide sufficient guidance as to the scope of the term "hospital services," we are required to take the second step of the *Chevron* inquiry:

> "[T]he question for the court is whether the agency's answer is based on a permissible construction of the statute." 467 U.S. at 843, 104 S.Ct. at 2782, 81 L.Ed.2d 694. The majority improperly avoided this question by concluding that the statute is unambiguous. The district court, however, did reach this issue and erred. Instead of deferring to the reasonable interpretation of the Boren Amendment enunciated by HCVA, the district court adopted what it considered a "more reasonable" interpretation of the statute. To do so was clearly inappropriate under *Chevron*. As we have stated in the past, we need not conclude that HCVA's interpretation of the Boren Amendment is "the only reasonable one, or even the 'best' one." *Queen of Angels*, 65 F.3d at 1477. We need *only conclude* that it is a "permissible" one. *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414, 113 S.Ct. 2151, 2159, 124 L.Ed.2d 368 (1993). We should so conclude.

It is true, as pointed out by the court below, that HCVA had not issued administrative regulations that resolved the interpretation of the Boren Amendment at the time appellees brought suit. As a consequence, the district court properly invited the United States, on behalf of HCVA and the Secretary of Health

and Human Services, to submit a brief outlining its interpretation of the Amendment. In response, the United States submitted a detailed brief opining that the Boren Amendment *did not* apply to out-of-state hospitals. The district court subsequently rejected that interpretation in favor of its own interpretation of the amendment. It declined to adopt HCVA's interpretation because, in the words of the district court, such an interpretation was "inconsistent" with the agency's prior interpretations of the Amendment.

I disagree with that conclusion for two reasons: (1) HCVA's proposed interpretation of the Boren Amendment is reasonable, and (2) even if HCVA's interpretation was inconsistent with its prior interpretations of the Amendment, that is of no consequence. The position HCVA has taken is a reasonable one. It should be the controlling one.

A. *HCVA's Interpretation of the Boren Amendment.*

HCVA, in concluding that the Amendment does not apply to out-of-state hospitals, based its position upon the tenet that the Boren Amendment was enacted to provide "greater flexibility" to the participating states and that applying the Amendment to out-of-state hospitals would have created an administrative morass that Congress could not have intended. The Boren Amendment, to repeat, required a state to audit every provider of health care services to Medicaid patients to determine whether the provider charges reasonable rates. In its brief to the district court, HCVA noted that if it required states to apply this rubric to out-of-state providers, states such as California would have to analyze data for each out-of-state facility even if that facility ultimately cares for only one of its residents. Moreover, HCVA noted that if it required states to apply the Boren Amendment to out-of-state hospitals, states would need to employ experts to learn licensure laws of other states to determine whether facilities in other states have adequate staff and are running "efficiently" and "economically." In short, according to HCVA, the costs would be overwhelming and would defeat the purpose of the Boren Amendment.

The legislative history of the Boren Amendment also influenced HCVA in formulating its interpretation of the statute. It pointed out that the stated intent of the Amendment was to provide states with the maximum amount of flexibility in setting payment rates. HCVA noted that it would make little sense under this framework to require states to obtain information regarding every out-of-state provider that provides services to even one Medicaid eligible resident.

Instead, HCVA concluded that another provision, known as the "equal-access" provision, governs the reimbursement of out-of-state providers. It relied on 42 U.S.C. § 1396a(a)(30)(A), and argued to the district court that this statute, not the Boren Amendment, regulates state payments to out-of-state providers. That provision, requires, in pertinent part that a state plan

> provide for methods and procedures relating to ... the payment for[ ] care and services available under the plan ... to assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (1998).

HCVA concluded that this "equal access" provision is better tailored to ensure that states are providing adequate reimbursement to out-of-state providers of medical services to Medicaid patients because it is less burdensome than applying the Boren Amendment. In short, in the view of HCVA, this provision requires a state to ensure that its payments to out-of-state providers are *reasonable* without requiring the state to engage in a facility-specific analysis for every provider in every state where a patient may receive services.

This interpretation of the Medicaid statutory scheme is reasonable. Whether it is the best interpretation or the most fair interpretation is not controlling. It is a reasonable one. Therefore, in obedience to the Supreme Court's dictates in *Chevron*, I would hold that it is a permissible interpretation of an ambiguous statute. Because HCVA, not the courts, is entrusted with carrying out the provisions of Medicaid, I would defer to its interpretation of this ambiguous statutory provision.

B. *The District Court's Inconsistency Argument.*

The district court erred when it disregarded HCVA's interpretation because it found it "inconsistent." In the *Chevron* decision itself, the administrative agency charged with implementing the relevant statute had changed its interpretation of the challenged statute multiple. times. The respondents in *Chevron* contended that because the agency changed its interpretation of the statute so often, the Court should have afforded it no deference. The Supreme Court disagreed and noted that: "The fact that the agency has from time to time changed its interpretation of the" relevant statute "does not ... lead us to conclude that no deference should be accorded the agency's interpretation of the statute.... [T]he agency, to engage in informed rulemaking, must consider varying interpretations and the wisdom of its policy on a continuing basis." *Chevron*, 467 U.S. at 863-64, 104 S.Ct. at 2792, 81 L.Ed.2d 694.

In ignoring HCVA's interpretation, the district court offered no reason other than the fact that HCVA supposedly changed its position regarding the interpretation of the Boren Amendment over time.[4/] This is not determinative. Had HCVA, for example,

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4. Moreover, I do not believe that HCVA's position on this issue was at all inconsistent. The district court noted that HCVA, before the filing of this lawsuit, had never officially announced its position on the interpretation of the Boren Amendment. The court below instead relied on a district court decision, *Multicare Medical Center v. Washington*, 768 F.Supp. 1349, 1401 (W.D. Wash.

changed its position because it somehow was in its advantage to do so, one should be inclined to reject its interpretation of the statute. That did not happen in this case, however. Therefore, we should defer to HCVA's good faith attempt to interpret a complex statute with which it was charged to implement.

For the foregoing reasons, I respectfully dissent.

1991), to reach its conclusion that HCVA has been inconsistent in its position on the applicability of the Boren Amendment to out-of-state hospitals. In *Multicare*, the district court concluded that the Boren Amendment required Washington to make payments to out-of-state providers. In reaching its conclusion, the district court relied on correspondence between a HCVA regional office and the State of Washington. HCVA's Central Office, however, had never announced a policy that embraced the view of its regional office. According to HCVA, only its Central Office actually has the authority to announce such policies. It was of no consequence, therefore, that a regional office concluded otherwise.

The district court relied on similar correspondence between a HCVA regional office and California to support its position. HCVA offered two plausible explanations for this correspondence as well. First, HCVA notes that the correspondence never expressly states that the Boren Amendment applies to out-of-state hospitals. Second, HCVA notes that even if we were to construe this correspondence as declaring that the Boren Amendment applies to out-of-state hospitals, this view represents only the views of a regional office not empowered to make centralized HCVA policies.

I find HCVA's explanations sufficient and would find no inconsistency.

APPENDIX B

FILED
Dec 17 1999
CATHY A. CATTERSON, Clerk
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CHILDREN'S HOSPITAL AND HEALTH CENTER, a Washington corporation;

Plaintiff-Appellee,

v.

S. KIMBERLY BELSHE, Director, California Department of Health Services,

Defendant-Appellant.

No. 98-15559

D.C. No. CV-95-01076 MHP

ORDER

Before: SNEED, THOMPSON and W. FLETCHER, Circuit Judges.

The panel, as constituted above, has consolidated the appellant's petition for rehearing and for rehearing en banc. Judges Thompson and Fletcher voted to deny the petition for rehearing. Judge Sneed voted to grant the petition. Judge Fletcher voted to deny the petition for rehearing en banc and Judge Thompson recommended denial. Judge Sneed recommended that the petition for rehearing en banc be granted.

A judge of the court called for a vote on the petition for rehearing en banc. A vote was taken, and a majority of the active judges of the court failed to vote for en banc rehearing. Fed.R.App.P.35(f).

The petitions for rehearing and for rehearing en banc are DENIED.

APPENDIX C

FILED
Feb 5, 1998
RICHARD W. WIEKING
Clerk, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CHILDREN'S HOSPITAL AND MEDICAL CENTER, a Washington corporation, et al.

Plaintiffs,

vs.

S. KIMBERLY BELSHE, Director, California Department of Health Services,

Defendant.

No C-95-1076 MHP

MEMORANDUM AND ORDER

Plaintiff Children's Hospital and Medical Center ("Children's Hospital"), a hospital located in the State of Washington, along with a number of other hospitals located outside the State of California, bring this action against defendant S. Kimberly Belshe, Director of the California Department of Health Services ("CDHS"), alleging that California's reimbursement scheme for out-of-state hospitals which

provide care for Medi-Cal beneficiaries does not comply with the requirements of the Boren Amendment to the Social Security Act, 42 U.S.C. § 1396a(a)(13)(A) (1992), and the regulations promulgated to implement it, 42 U.F.R. Part 447 (1994). Plaintiffs seek declaratory and injunctive relief.

This court, in its order dated January 9, 1997, determined that the procedural and substantive requirements of the Boren Amendment apply equally to both hospitals located within California and out-of-state hospitals. The court now makes a very narrow inquiry into whether contractual negotiations between California hospitals and the CDHS under California's Selective Provider Contracting Program ("SPCP"), Cal. Welf. & Inst. Code § 14081 et seq., which determine reimbursement rates for in-state hospitals are "procedurally" sufficient to constitute "findings" as required by the Boren Amendment for the reimbursement rate scheme provided to out-of-state hospitals.

Having considered the parties' arguments and submissions, and for the reasons set forth below, the court enters the following memorandum and order.

BACKGROUND

A. The Boren Amendment

Prior to the passage of the Boren Amendment, states were required to reimburse hospitals for the "reasonable cost" of providing inpatient services. This generally took the form of retrospective payments based on a hospital's costs for a given service. See West Virginia University Hospitals, Inc. v. Casey, 885 F.2d 11, 15 (3rd Cir. 1989), aff'd on other grounds, 499 U.S. 83 (1991).

The Boren Amendment, however, allowed each state to adopt a prospective rate-setting scheme which fixed in advance the reimbursement rates given to health care providers for inpatient services provided to Medicaid patients. The Boren Amendment required that a state plan for medical assistance had to provide

> for payment ... of the plan through the use of rates (determined in accordance with methods and standards, developed by the State ... and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services.

42 U.S.C. § 1396a(a)(13)(A) (emphasis added). The main purpose of the Boren Amendment was two-fold: first, it encouraged the provider to meet the rate or to absorb the loss if the provider's actual costs exceeded that rate, and second, it gave the states more flexibility in determining their own payment methods.[1] S. Rep. No. 97-139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong. & Admin. News 744; see also Wiler v. Virginia Hospital Ass'n, 496 U.S. 498, 515 n.13 (1990) (discussing the legislative history of the Boren Amendment).

The Boren Amendment created both a procedural and substantive requirement in the adoption of reasonable and adequate reimbursement rates by states to Medicaid providers.[2] Wilder, 496 U.S. at 513. Procedurally, a state first had to make "findings" identifying the reasonable costs incurred by efficiently and economically operated hospitals and in identifying payment rates which were reasonable and adequate to meet those costs. A state also had to make "assurances" to the Health Care Financing Administration ("HCFA") that the findings were made according to the requirements of law and that individuals have "reasonable access" to facilities of "adequate quality." 42 C.F.R. § 447.252 (a) & (b)(1)(i); see also Folden v. Washington State Dept. of Social and Health Serv., 981 F.2d 1054, 1057 (9th Cir. 1992). The findings requirement was "a necessary prerequisite" to the subsequent requirement that the State provide "assurances" to the Secretary. Wilder, 496 U.S. at 513.

The substantive element of the Boren Amendment required states to reimburse facilities at "reasonable and adequate" rates, namely, the cost which would be incurred by an efficiently operated provider. While this did not mean that all actual costs would necessarily be reimbursed, the reimbursement rate had to be reasonable based on the state's previous findings. Kansas Health care Ass'n v. Kansas Dept. of Social & Rehab. Serv., 31 F.2d 1536, 1546 (10th Cir. 1994). The Supreme Court noted that while "the Amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates," it is not unreviewable discretion as there are rates that would certainly fall outside the range of reasonableness. Wilder, 496 U.S. at 519. Some courts have followed this lead by evaluating whether reimbursement methods fall within a "zone of reasonableness." Folden, 981 F.2d at 1058 (citations omitted); W. V. Univ. Hosp., 885 F.2d at 26.

A state had also to set reimbursement rates for inpatient hospital services that take into account hospitals that serve a disproportionate share of low-income patients and the recipients' access to such services. 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. 447.253(b)(1)(ii). Because of the unique financial needs of the disproportionate share hospitals ("DSH"), a state had to make payment adjustments for which a federal contribution is available. 42 U.S.C. § 1396r-4. This is known as the "DSH requirement" of the Boren Amendment.

In implementing the Boren Amendment, the Secretary chose not to define "reasonable and adequate" payment rates. Rather, in order to preserve the states' flexibility in the setting of reimbursement rates, the Secretary reviewed the states' assurances to ensure that the states made findings necessary to fix payment rates which met the Boren Amendment's requirements. 42 C.F.R. § 447.253(a) & (b). The state, however, was not required to submit the findings themselves or the underlying data, and the assurances offered by the state are considered satisfactory in the absence of formal notification to the contrary. 42 C.F.R. § 447.256.

B. Repeal of the Boren Amendment

Portions of the Boren Amendment have recently been repealed and revised by section 4711 of the Balanced Budget Act of 1997, P.L. 105-33, 11 Stat. (1997), which was signed into law on August 5, 1997. Section 4711 applies only to payments for "items and services furnished on or after October 19, 1997." P.L. 105-33 § 4711(d).

Section 4711 repeals the "findings" and "assurances" methodology enumerated in the Boren Amendment. In its stead, section 4711 requires a state to create a "public process for determination of rates of payment under the plan." 42 U.S.C. § 1396a(a)(13)(A)(i), (ii) (1997). Furthermore, section 4711 requires that the rates "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A)(iv) (1997). Thus, the repeal of the Boren Amendment significantly modifies the existing rate-setting scheme. However, the Act affects only payments made to out-of-state hospitals for items and services furnished on or after October 1, 1997.

C. The State's reimbursement plan

1. Out-of-state reimbursement methodology

In 1992, the California Legislature enacted a statutory provision mandating a specific methodology to be used in reimbursing out-of-state hospitals for inpatient treatment provided to Medi-Cal patients:

> [n]otwithstanding any other provision of law, reimbursement for out-of-state acute inpatient hospital services provided to Medi-Cal beneficiaries shall not exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charged, whichever is less.

Cal. Welf. & Inst. Code § 14105.15(i) (effective September 14, 1992). The Legislature amended the existing inpatient hospital reimbursement methodology for out-of-state hospitals in large part to effect cost-savings in Medi-Cal payments. Johnson Decl., Ex. C.

The CDHS subsequently promulgated an emergency regulation implementing the statutory mandate, and began reimbursing out-of-state hospitals according to the statutory mandate on October 16, 1992. 22 Cal. Code of Reg. § 51543(a); see also Johnson Decl., Ex. I. In a letter dated October 21, 1992, the CDHS submitted various assurances to HCFA regarding the State's change in calculating reimbursement rates for out-f-state hospitals for hospital inpatient services. Johnson decl., Ex. I; see 42 C.F.R. 447.250-272. HCFA initially refused to approve California's reimbursement plan and requested additional related information and clarification. Johnson Decl., Ex. J at 1. The CDHS subsequently submitted the information necessary to secure HCFA's approval of the amendment to the reimbursement methodology for out-of-state hospitals. Johnson Decl., exs. K & L. Under the new reimbursement scheme, it appears that no DSH payments have been made to out-of-state hospitals. Johnson Decl., Exs. O, P, Q.

2. *In-state payments*

Reimbursement rates for most in-state hospitals are set via contractual negotiations between the CDHS and the specific hospitals which provide inpatient services to Medi-Cal beneficiaries. These contracts are negotiated pursuant to the State's SPCP. See Cal. Welf. & Inst. Code § 14081 et seq.; 22 Cal. Code of Regs. § 51541. The California Legislature enacted the SPCP in order to "ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible." Cal. Welf. & Inst. Code § 14081. One of the reasons which the CDHS provides for using contractual negotiations in setting payment rates is because "[s]ignificant excess capacity exists in the California health care delivery system" which provides "the environment for competition." Id. ¶ 2.

The CDHS operates the SPCP pursuant to a waiver from the Boren Amendment requirements granted by the Secretary of the Health and Human Services. Chell Decl., Ex. A ¶ 4. The SPCP process is therefore exempt from the Boren Amendment's findings process for those hospitals under the State's contracting scheme. In negotiating contractual rates, the State negotiator is required to consider at least sixteen statutory factors which the Legislature considers relevant in setting the rate of reimbursement.[3] Cal. Welf. & Inst. Code § 14083. Negotiations appear to involve a fairly long process of give-and-take between the CDHS and the hospitals involved in the negotiation. Chell Decl., Ex. A ¶¶ 11-13. It is unclear, however, the extent to which the negotiators explicitly or implicitly evaluate each of the factors and the weight given to each factor. In-state hospitals which are designated as disproportionate share hospitals under state criteria are also eligible to receive disproportionate share supplemental reimbursements in addition to the contractually agreed upon rate of payment. Cal. Welf. & Inst. Code § 14085.5.

Presently, approximately 260 California hospitals, which represent nearly 90 percent of the inpatient days of care rendered to Medi-Cal beneficiaries, are under contract with the State pursuant to the SPCP. Chell Decl., Ex. A ¶ 14. At the hearing on this matter, the State's counsel explained that reimbursement rates paid to the other ten percent of the in-state hospitals which provided inpatient services to Medi-Cal recipients were not exempt from the Boren Amendment's procedural requirements. For these hospitals, the State's counsel noted that the CDHS accumulates substantial data with respect to individual hospital hospitals and undertakes a complex analysis of the data to determine the payment rate appropriate for economically and efficiently run hospitals. Finally, defendant's counsel made it clear at the hearings that out-of-state hospitals did not receive DSH payments.

LEGAL STANDARD

A. Summary Judgment

Under Federal Rule of Civil Procedure 56, summary judgment shall be granted "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial ... since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." Celotex Corp. v. Catrett, 477 U.S. 317, 322-323 (1986).

B. Review of Boren Amendment

Whether the State has complied with the procedural findings requirement imposed by the Boren Amendment is a question of law subject to de novo review. Abbeville General Hospital v. Ramsey, 3 F.3d 797, 802 (5th Cir. 1993). See also Wilder, 496 U.S. at 512 n.18 (court's review of findings and assurances is plenary). In contrast, in reaching the substantive question of whether a payment rate is "reasonable and adequate" under the Boren Amendment, this court must recognize that the State's plan is the "product of legislative and policy decisions made at the federal and state levels." Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306, 1312-1313 (2nd Cir. 1991). The court's review is therefore limited to determining whether the state has acted arbitrarily, capriciously or contrary to the specific requirements of federal law. Folden, 744 F.Supp. at 1532.

DISCUSSION

The CDHS contends that the process underlying the State's contractual negotiations with California hospitals is procedurally sufficient to constitute "findings" under the Boren Amendment for the reimbursement rates provided to out-of-state hospitals. It argues that the rate setting methodology "implicitly" incorporates

the required "findings" since the negotiator is statutorily mandated to consider numerous factors in arriving at the appropriate reimbursement rate during contract negotiations. Plaintiffs, however, contend that the CDHS, by setting out-of-state hospital reimbursement rates by simply averaging contractually negotiated in-state hospital payment rates, fails to carry out the requisite findings necessary to provide a basis for a reasonably principled analysis for setting payment rates.

The Ninth Circuit has noted that if the state agency has engaged in a "bona fide fact-finding process," then the procedural requirements are satisfied. Folden va. State of Washington Dept. of Social and Health Serv., 744 F.Supp.1507, 1532 (W.D. Wash. 1990), aff'd Folden v. Washington State Dept. of Social and Health Serv., 981 F.2d 1054 (9th Cir. 1992) quoting Amisub (PSL), Inc. v. State of Colorado Department of Social Services, 879, F.2d 789, 797 (10th Cir. 1989)). Although "a State is on notice that it cannot adopt any rates it chooses and that the requirement that it make `findings' is not a mere formality," the states are free to create their own methods of arriving at the required findings and the findings process does not require any special studies or written findings. Wilder, 496 U.S. at 514. The states therefore retain a fairly high degree of discretion in determining what kinds of findings are necessary to meet the Boren Amendment's procedural requirements.

In Amisub, the Tenth Circuit articulated what has become the accepted test for procedural compliance with the Boren Amendment in many circuits. The states must, "at a minimum, ... make `findings' which identify and determine (1) efficiently and economically operated [facilities]; (2) the costs that must be incurred by such [facilities]; and (3) payment rates which re reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated [facilities]." Amisub, 879 F.2d at 796; Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1294 (8th Cir. 1981), cert. denied 479 U.S. 1063 (1987); Pinnacle, 928 F.2d, at 1314-15 (2nd Cir. 1991); Temple University v. White, 941 F.2d 201, 209 n.10 (3rd Cir. 1991). See also Folden,

744 F.Supp. at 1532; Multicare Medical Center v. Washington, 768 F.Supp. 1349, 1391 (W.D. Wash. 1991).

In applying these broad rules to the present case. courts have reviewed the procedural sufficiency of a state's findings with varying degrees of scrutiny. For instance, the district court in Folden undertook an extensive examination of the "testimony from officials of the State [of Washington] and from experts evaluating the state procedures and findings concerning the rates involved." Folden, 981 F.2d at 1059. Other courts have made a similar probing inquiry into the findings made by a state because "whatever methods a state uses in arriving at the procedurally required findings, such findings must be correct." NJHA, 73 F.3d at 518. At the least, several courts have noted that a state cannot merely recite the wording of the Boren Amendment in order to meet the procedural findings requirement. Amisub, 879 F.2d at 797 ("[m]ere recitation of the wording of the federal statute is not sufficient for procedural compliance"); Pinnacle, 928 F.2d at 1315 (state cannot "merely make [] conceptual policy decisions:); see also Wilder, 496 U.S. at 516-21 (state must judge the reasonableness of its rates against the objective benchmark of an efficiently and economically operated facility).

Few courts have dealt with either the argument that "findings" are implicit in some underlying methodological process or that rates set via a state's selective contracting program may pass the Boren Amendment's procedural muster. However, the Multicare Med. Ctr. court dealt with similar issues in considering whether reimbursement rates set by the State of Washington's Department of Social and Health Services ("DSHS") met the Boren Amendment's procedural requirements. In Multicare Med. Ctr, the DSHS asserted that the State of Washington's rate setting scheme met the procedural findings requirements because the findings were "implicit" in the State's rate setting methodology. Multicare Med. Ctr., 768 F.Supp. at 1392. The State further asserted that the rates were reasonable and adequate because the payment rates based on the rate setting methodology were equal to or greater than rates set through negotiations conducted as part of the State's selective contracting program. Id. at 1382.

The Multicare Med. Ctr. court flatly rejected both of these contentions. First, the court held that State's methodology was insufficient to meet the Boren Amendment's procedural requirements since the methodology failed to set an "objective benchmark" for an "economically and efficiently operated hospital." Id. (citing Wilder, 496 U.S. at 520). Thus, the court held that "findings" could not be considered to be "implicit" in any rate setting methodology. In considering the State's selective contracting program, the court found that "the results of the selective contracting program, whether considered alone or in conjunction with other factors considered by the State ..., do not provide a sufficient factual basis for the State's finding and assurance that the payment rates satisfied the Boren Amendment requirements." Id. at 1395.

Finally, the Third Circuit has rejected a state plan with respect to out-of-state hospitals for failing to make the requisite findings under the Boren Amendment. W. Va. Univ. Hosp., 885 F.2d at 30. In W. Va. Univ. Hosp., the State of Pennsylvania admitted to gathering no information with respect to the actual costs incurred by the out-of-state hospitals, and to failing to conduct an empirical analysis to measure the effects of the reimbursement program on out-of-state hospitals or even identifying large out-of-state hospitals. Id. In concluding that the State failed to distinguish between in-state and out-of-state hospitals in making findings, the court stated that "[a] policy predicated upon provincialism and self-interest, not upon findings of reasonableness and adequacy is unacceptable." Id.

The CDHS has clearly failed to meet the Boren Amendment's procedural requirements in setting reimbursement rates for out-of-state hospitals under the standards set forth in W. Va. Univ. Hosp. and Multicare Med. Ctr. Although the CDHS admits to undertaking a comprehensive analysis in setting payment rates for those in-state hospitals which do not under the SPCP, it did not conduct any findings whatsoever for out-of-state hospitals. As in W. Wa. Univ. Hosp., the failure to place in-state and out-of-state hospitals on the same footing in making findings and assurances is contrary to the procedural requirements set forth in

the Boren Amendment. Furthermore, the State's explanation that "findings" were implicit in the factors relied on by CDHS' negotiators during the contracting process is not sufficient. It is clear that the rationale supplied by the CDHS that contractual negotiations were impliedly findings "is merely an exercise to make the best case to support the State's rates." Multicare Med. Ctr., 768 F.Supp. at 1392. The CDHS gathered no information on the costs incurred by out-of-state hospitals and performed no empirical analysis of the effects of the reimbursement scheme on out-of-state hospitals. The CDHS therefore failed to provide any basis for a reasonably principled analysis in determining whether the payment rates that it provides to out-of-state hospitals are "reasonable and adequate." The court therefore finds that the CDHS has failed to meet the Boren Amendment's procedural findings requirements in setting reimbursement rates for out-of-state hospitals.

Finally, plaintiffs contend that the CDHS has not made any DSH payments to out-of-state hospitals since the 1992 statutory payment provision took effect and thus violates the Boren Amendment. The CDHS does not deny that it has not made any DSH payments, and in fact, claims that it does not have to make DSH payments to out-of-state hospitals. The State, however, is required by the Boren Amendment and its implementing regulations "to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A). See also W. Va. Univ. Hosp., 885 F.2d at 24 (Pennsylvania required to make DSH payments to out-of-state hospitals); 42 C.F.R. § 447.253(b(1)(ii)(A) (1988). The requirement does not distinguish between in-state and out-of-state hospitals. The State has made no DSH payments to out-of-state hospitals, nor has it made any findings as to whether any out-of-state hospitals serve a disproportionate number of low-income patients with special needs in order to determine whether these hospitals are entitled to receive DSH payments. The CDHS' gross failure to make any determination as to whether out-of-state hospitals are entitled to receive DSH payments is clearly in violation of the Boren Amendment's requirements.

CONCLUSION

This court hereby finds that the CDHS failed to meed the procedural requirements of the Boren Amendment in setting reimbursement rates for out-of-state hospitals which treat Medi-Cal inpatients. The court further holds that the CDHS is obligated under the Boren Amendment and implementing regulations to make DSH payments to out-of-state hospitals.

Furthermore, this court's determination that the Boren Amendment applies to out-of-state hospitals and that the CDHS failed to meet the Boren Amendment's procedural findings requirement in setting reimbursement rates for out-of-state hospitals involves a controlling question of law as too which there may be substantial ground for difference of opinion. the court therefore finds that an immediate appeal from this order and the order issued by this court on January 9, 1997, may materially advance the ultimate termination of this litigation. It therefore GRANTS the State's petition for interlocutory appeal. The court further stays this action pending the proceedings and decision of the United States Court of Appeals for the Ninth Circuit.

This motion fully adjudicates the motions reflected at Docket #42 and #38 and the Clerk of the Court shall remove it from the pending motions list.

IT IS SO ORDERED.

Dated: February 4, 1998

MARILYN HALL PATEL
United States District Judge

ENDNOTES

1. The CDHS appears to confuse the prospective nature of the Boren Amendment's envisioned reimbursement scheme with a retrospective payment scheme which investigates whether each billed charge is reasonable. Def. Opp., at 4. In doing so, the CDHS argues that a requirement that it identify and evaluate each and every out-of-state hospital in setting its payment rate would be burdensome. The CDHS' argument misses the point of the Boren Amendment. The goal of the Boren Amendment is to permit states to alter their reimbursement plans to encourage providers to contain health care costs and to give states greater flexibility in calculating reasonable costs. Folden, 981 F.2d, at 1056. Thus, the Boren Amendment obviates the need for states to investigate each cost report filed by a hospital to determine whether the costs incurred are concomitant with economically and efficiently run hospitals.

2. The Third Circuit has noted that the line between the procedural and substantive dimensions of the Boren Amendment is "often blurred." New Jersey Hospital Ass'm v. Waldman, 73 F.3d 509, 513 (3rd Cir. 1995).

3. Among the factors considered are "(a) beneficiary access; (b) utilization controls; (c) ability to render quality services efficiently and economically; (d) demonstrated ability to provide or arrange needed specialized services,... (f) any other factors which would reduce costs, promote access, or enhance quality of care, ... (k) the special circumstances of hospitals serving a disproportionate number of Medi-Cal beneficiaries and patients who are not covered by other third-party payers..." Cal. Welf. & Inst. Code § 14083.

FILED
Jun 9 1997
RICHARD W. WIEKING
Clerk
U.S. DISTRICT COURT
NO. DIST. OF CA

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

CHILDREN'S HOSPITAL AND MEDICAL CENTER, a Washington corporation, et al.

Plaintiffs,

vs.

S. KIMBERLY BELSHE, Director, California Department of Health Services,

Defendant.

No C-95-1076 MHP

ORDER

Plaintiff Children's Hospital, a Washington state hospital, along with a number of other hospitals located outside California, bring this action against Defendant S. Kimberly Belshe, Director of the California Department of Health Services ("CDHS"), alleging the California's reimbursement scheme for out-of-state

hospitals who provide care for Medi-Cal beneficiaries does not comply with the requirements of federal law as articulated in the Boren Amendment to the Medicaid program, 42 U.S.C. § 1396a(a)(13)(A), and the regulations promulgated to implement it. 42 C.F.R. Part 447 (1994). Plaintiffs seek declaratory and injunctive relief.

Now before this court is defendant's motion for summary judgment on the grounds that the Boren Amendment does not apply to out-of-state providers of health care. The question is a legal one of statutory interpretation.

Having considered the parties' arguments and submissions, and for the reasons set forth below, the court enters the following memorandum and order.

BACKGROUND

A. Medicaid

Medicaid, Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., was created by Congress in 1965 as a jointly-founded program between the federal government and the states to govern the purchase of health care services for needy individuals. Unlike Medicare, which is administered nationally, Medicaid is administered by the individual states that choose to participate in the program. States are free not to participate, but once a state chooses to participate it is obliged to comply with various federal requirements laid out in the Act and its implementing regulations. 42 U.S.C. § 1396a; 42 C.F.R. §§430 et seq.

In order to be eligible for federal monies, a participating state must design a medical assistance plan (the "plan") detailing the scope of the state's coverage and to submit it to the Secretary of Health and Human Services. 42 U.S.C. § 1396a. Among other things, the plan must provide for the methodology the state will use to reimburse institutional health care providers for the services they render to Medicaid recipients. Ultimately the plan must be approved by the Heath Care Financing Administration ("HCFA"), the agency responsible for the administration of the Medicaid program at the federal level.

B. The Boren Amendment

Congress first changed the reimbursement standards to be applied by the states with respect to nursing home services in the Omnibus Budget Reconciliation Act of 1980, P.L. 96-499, § 962(a), and the next year extended that standard to the reimbursement of inpatient hospital services. Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, § 2173. This new methodology, known as the Boren Amendment, required that each state plan must provide

> for payment ... of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the state which, ... in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care, ... for lower reimbursement rates reflecting the level of care actually received ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws regulations, and quality and safety standards and to assure that all individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each [facility] and periodic audits by the State of such reports...."

42 U.S.C. § 1396a(a)(13)(A)(1992).

Prior to passage of the Boren Amendment, states were required to reimburse hospitals the "reasonable cost" of providing inpatient services. This generally took the form of retrospective payments based on a hospital's actual costs for a given service. See West Virginia University Hospitals, Inc v. Casey, 855 F.2d 11, 15 (3rd Cir. 1989), aff'd on other grounds, 499 U.S. 83 (1991).

Under the Boren Amendment, reimbursement tends to be prospective, fixed in advance according to a scheme devised by each state to classify certain providers and procedures. The main purpose of this statutory change in the standard for calculating reimbursement rates was two-fold; first, to create an incentive to bring down escalating medical costs by paying reasonable rates based on the costs that would be incurred by "efficiently and economically operated facilities" and second, to give states more flexibility in determining their own payment methods. S. Rep. No. 97-139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong. & Admin. News 744; see also Wilder v. Virginia Hospital Ass'n, 496 U.S. 498, 515 n.13 (1990) (discussing the legislative history of the Boren Amendment).

Courts have found that the Boren Amendment imposes both a procedural and substantive requirement on states. Procedurally, a state must make "findings" identifying the reasonable costs incurred by efficiently and economically operated hospitals, the payment rates which are reasonable and adequate to meet those costs, and it must take "assurances" to the HCFA that the findings have been made according to the requirements of law. 42 C.F.R. § 447.253 (a) & (b)(1)(i); see also AMISUB (PSL), Inc v. Colorado Dept. of Social Serv., 879 F.2d 789,796 (10th Cir. 1989), cert. denied, 496 U.S. 935 (1990).

Additionally, a state must set reimbursement rates for inpatients hospital services that take into account hospitals that serve a disproportionate share of low-income patients and the recipients' access to such services. 42 C.F.R. § 447.253 (b) (1) (ii). Because of the unique financial needs of disproportionate share hospitals ("DSH"), a state must make payment adjustments for which a federal contribution is available. 42 U.S.C. § 1396r-4.

This is known as the "DSH requirement" of the Boren Amendment.

The substantive element of the Boren Amendment requires states to reimburse facilities at reasonable and adequate rates, namely, the cost which would be incurred by an efficiently operated provider. While this does not mean all actual costs will necessary be reimbursed, the reimbursement rate must be reasonable based on the state's previous findings. Kansas Health Care Ass'n. v. Kansas Dept. of Social & Rehab. Serv., 31 F.2d 1536, 1546 (10th Cir. 1994). Addressing this rather elusive standard of reasonableness under the Boren Amendment the Supreme Court has noted that while "the Amendment gives the States substantial discretion in choosing among reasonable methods of calculating rates", it is not unreviewable discretion as there are rates that would certainly fall outside the range of reasonableness. Wilder, 496 U.S. at 519. Other courts have followed this lead by evaluating reimbursement methods according to a "zone of reasonableness." Folden v. Washington State Dept. of Social & Health Serv., 981 F.2d 1054, 1058 (9th Cir. 1992) (citation omitted); West Virginia Univ. Hosp., 885 F.2d at 26.

In implementing the Boren Amendment, the Secretary has chosen not to define "reasonable and adequate" payment rates. Rather, in order to preserve the flexibility of the states, the Secretary reviews the states' assurances that they have made findings that their payment rates meet the statutory requirements. 42 C.F.R. § 447.253(a) & (b). The states is not required to submit the findings themselves or the underlying data, and the assurances offered by the state are considered satisfactory in the absence of formal notification to the contrary. 42 C.F.R. § 447.256.

C. HCFA Participation in the Action

Before receiving the defendant's motion for summary judgment in this action, the Court contacted the regional office of HCFA inviting it to participate as an amicus curiae. HCFA has not responded by the time the motion was fully briefed by the

parties, and the Court head oral argument on the motion on November 3, 1995.

On November 30, 1995, the Court was notified by HCFA's central office that it is was seeking formal authorization from the Department of Justice to file an amicus brief. By order dated December 18, 1995, the Court gave HCFA sixty days to file its brief. One extension of time was granted and HCFA submitted an amicus brief on March 1, 1996. The parties were then given until April 9, 1996, to file briefs in response.

HCFA interprets the Boren Amendment as not applying to out-of-state hospitals.

LEGAL STANDARD

Under Federal Rule of Civil Procedure 56, summary judgement shall be granted "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial ... since a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial." Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1996); see also T.W. Elec. Serv. V. Pacific Elec. Contractors Ass'n, 809 F.2nd 626, 630 (9th Cir. 1987) (the nonmoving party may not rely on the pleadings but must present significant probative evidence supporting the claim); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986) (a dispute about a material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.").

The court's function, however, is not to make credibility determinations, Anderson, 477 U.S. at 249, and the inferences to be drawn from the facts must be viewed in a light most favorable to the party opposing the motion. T.W. Elec. Serv., 809 F.2d at 631.

DISCUSSION

I. Analytical Framework

As in all statutory construction, the starting point is the language of the statute itself. United States v. James, 478 U.S. 597, 604 (1986). If the intent if Congress is unambiguous, then courts must give that intent effect. Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984). However, if a statute is ambiguous or silent on the question at issue, a court will generally defer to a permissible construction by the agency empowered to administer the statute. Id. at 843; see also Good Samaritan Hosp. v. Shalala, 508 U.S. 402, 414 (1993) (citations omitted); accord Queen of Angels/Hollywood Presbyterian Medical Center v. Shalala, 65 F.3d 1472, 1477 (9th Cir. 1995). In other words, absent some showing that the agency's interpretation defies Congressional intent, a court cannot substitute its own interpretation for a reasonable interpretation offered by the agency. Chevron, 467 U.S. at 843 n.9; Queen of Angels, 65 F.3d at 1477.

However, the judiciary is also the final authority of issues of statutory construction, and judicial deference, while setting the framework for the analysis of a statute, does not displace it. Securities Indus. Ass'n v. Board of Governors of the Federal Reserve System, 468 U.S. 137, 143 (1984) (citations omitted). Moreover, while an agency is not prohibited from changing its mind, Good Samaritan Hosp., 508 U.S. at 417, "the consistency of an agency's position is a factory in assessing the weight that position is due." Id.

An agency's interpretation of its own regulations is entitled to substantial deference. See e.g., Shalala v. Guernsey Memorial Hosp., ___ U.S. ___, 115 S.Ct. 1232, 1236 (1995) (quoting Lyng v. Payne, 476 U.S. 926, 939 (1986); Thomas Jefferson Univ. v. Shalala, ___ U.S. ___, 114 S.Ct. 2381, 2386 (1994) accord, Providence Hosp. of Toppenish v. Shalala, 52 F.3d 213, 216 (9th Cir. 1995).

II. Analysis

The parties agree on two preliminary and fundamental matters. One, Medicaid beneficiaries are entitled to some hospital services when they are not in their home state. 42 U.S.C. § 1396(a) (16); 42 C.F.R. § 431.52. Two, out-of-state hospitals require some form of reimbursement when they provide services to the beneficiaries of another state. 42 C.F.R. § 431.52(b). The crux of the disagreement is over the method used to calculate that reimbursement and whether it must meet the requirements of the Boren Amendment.

Defendant argues that the Boren Amendment was never intended to apply to out-of-state hospitals because 1) the structure of the Social Security Act requires such an interpretation, 2) application to out-of-state hospitals would be contrary to the purposes of the Amendment by robbing states of flexibility, and 3) administratively it would be impractical to require states to reimburse out-of-state hospitals according to the requirements of the Boren Amendment.

HCFA's chief argument is that it would be virtually impossible for states to comply with the Boren Amendment with respect to out-of-state hospitals because it would require them to make prospective findings and assurances specific to every hospital outside its borders where one of its residents might receive care. HCFA also argues that 42 U.S.C. section 1396a (a) (30) (A), the "equal access" provision of the Medicaid statute, rather than the Boren Amendment, governs reimbursement of out-of-state providers.

A. Deference Accorded HCFA

Plaintiffs contend that HCFA's interpretation of the Boren Amendment is entitled to no deference because it is contrary to the intent of Congress, to judicial interpretation, and to its own prior actions. HCFA, while conceding that it has never formally articulated its position in a regulation, interpretive rule or policy statement, argues that in the fifteen years since the Boren

Amendment was passed its actions have been consistent with the position that the Amendment does not apply to out-of-state hospitals. In addition, HCFA asserts that because its interpretation is supported by the legislative history, it deserves full deference.[4]

The court is aware of at least two instances where HCFA has implied that the Boren Amendment is applicable to out-of-state hospitals. In Multicare Medical Center v. Washington, 768 F. Supp. 1349, 1401 (W.D. Wash. 1991), a district court in Seattle found that the Boren Amendment required Washington to make DHS payments to out-of-state border hospitals that served the state's Medical recipients. In reaching this conclusion, the court noted that HCFA had informed the state that it was required to make such payments. Id. at 1388.

In addition, plaintiffs submit correspondence between HCFA and CDHS from 1992 and 1993 in which CDHS provided assurances with respect to proposed changes in its state plan regarding the reimbursement of out-of-state hospitals. Decl. of Dean Johnson, Exh. C at 1. Those assurances were not only provided pursuant to the Boren Amendment's implementing regulations, id., but they were reviewed by HCFA "in accordance with the statutory requirements of section 1902 (a) (14) [the Boren Amendment], 1902 (a) (30) and 1923 of the Social Security Act (the Act) and the implementing Federal regulations found at 42 CFR 447.250 through 447.272." Johnson Decl., Exhs. D at 1, F at 1. Moreover, HCFA did not approve the assurances and asked for further clarification on the notice provided and on California's DHS payments to out-of-state hospitals. Johnson Decl., Exh. D at 2.

HCFA protests that in both these instances the representations were made by its regional offices, which are not authorized to establish Medicaid policy. HCFA further assures that the court need not be concerned with the language used in reviewing California's assurances as it is standard boilerplate that HCFA includes each time it reviews a state plan.

The court finds HCFA's arguments neither reassuring nor convincing. While the regional offices of HCFA do not formulate

Medicaid policy, one would presume that their actions are in accord with the policy they are charged with carrying out. Even HCFA's amicus brief supports such a presumption. HCFA argues that the language in question referring to the statutory sections that comprise the Boren Amendment is "part of a standardized paragraph which HCFA typically includes in all letters reviewing SPAs affecting payment methods and standards. HCFA Amicus Brief at 19 n.7. HCFA does not contend this is regional boilerplate, but refers to it as HCFA's standard language. HCFA further argues that the language is not tailored to the SPA under review. The difficulty with this argument is that the only plan amendment under review were ones governing reimbursement of out-of-state hospitals and it is abundantly clear that the regional administrator for HCFA actually reviewed California's amended plan according to the requirements of the so-called standardized paragraph-in other words, the Boren Amendment.[5] Johnson Decl., Exh. D. at 1-2. It appears to this court that HCFA at one time assumed that the Boren Amendment applied to out-of-state hospitals.

HCFA is correct that the Secretary is entitled to change her mind, and that "inconsistency is probable insufficient alone to invalidate her interpretation. "Queen of Angels, 65 F.3d at 1480. However, in Queen of Angels, the Ninth Circuit also found that the interpretation of the Social Security Act proffered by the Secretary was supported by the statute's legislative history and the apparent congressional intent. Id. at 1481. As such, that interpretation was plausible and entitled to deference. Id. For reasons elaborated below, this court finds HCFA's interpretation to be at odds with congressional intent. Coupled with the agency's inconsistency on the matter, HCFA's interpretation is subject to "considerably less deference" I.N.S. v. Cardoza Fonseca, 480 U.S. 421, 446 n.30 (1987) (quoting Watt v. Alaska, 451 U.S. 259, 273 (1981)). In fact, a court must reject an agency's construction of a statute if it would frustrate the policy Congress sought to implement. F.E.C. v. Democratic Senatorial Campaign Comm., 454 U.S. 27, 32 (1981).

Deference is particularly unwarranted where a construction espoused for the first time by counsel for an agency appears to conflict with a position taken by the agency at the administrative level. Securities Indus., 468 U.S. at 143-44 ("post hoc rationalizations by counsel for agency action are entitled to little deference").

Despite the court's conclusion that it cannot defer to HCFA's interpretation of the Boren Amendment, it's knowledgeable discussion of the issues in its amicus brief, particularly with respect to its own regulations, was nonetheless of enormous value to the court and its participation is greatly appreciated.

B. The Impracticability Argument

Defendant dedicates a good deal of energy to the argument that it would be an administrative nightmare to apply the Boren Amendment's cumbersome requirements to every out-of-state hospital that provides services to California's Medicaid recipients. Impracticability also forms the bulk of HCFA's rationale for its position.

Defendant and HCFA both march out the parade of horribles that would ensue if a state were made to conform its reimbursement of out-of-state hospitals to the requirements of the Boren Amendment. They point our that because the approval process for state plans is prospective, states would have to anticipate all out-of state providers where its residents might receive care and then establish payment rates- subject to findings and assurances-that are specific to each individual provider. This would be particularly difficult when two, and arguably three, of the four circumstances under which a state must pay for services rendered out-of-state are emergency situations. See 42 C.F.R § 431.52(b). Compounding the difficulty, according to HCFA, would be the necessity of determining whether the costs incurred by each out-of-state facility were consistent with the costs incurred by an "efficiently and economically operated facilit[y]". 42 U.S.C. §

1396a (a) (13) (A). This determination requires data on each facility and knowledge of that state's licensure laws.[4]

Defendant strains to bring this argument within the ambit of statutory interpretation by offering that Congress could not have intended to impose impossible burdens on the states and that applying the Boren Amendment would yield absurd results, which courts must avoid. Green v. Bock Laundry Mach.Co., 490 U.S. 504, 510-11 (1989). However onerous or unwelcome the burdens imposed by the Boren Amendment, this court finds nothing absurd about the administrative requirements of the Boren Amendment even as applied to out-of-state hospitals.

First, defendant argues that the Boren Amendment is so convoluted and compliance with it so horrendously difficult that in enacting it Congress created a monster. However, to the extent this is true it does not necessarily follow that the Amendment should not apply to out-of-state hospitals. In fact, if the statute is burdensome with respect to in-state reimbursement schemes, it is illogical to argue that Congress could not have intended it to apply to out-of-state hospitals because of the burden it would involve. If Congress intended the Boren Amendment to impose no burden on the states, then its application is equally absurd with respect to in-state and out-of-state hospitals alike.

The administrative burden imposed, without more, is not relevant to interpreting the statute. West Virginia Univ. Hosp., 885 F.2d at 29. ("Pennsylvania's excuse of administrative burden does not, in this case, provide a rational basis for WVUH's grossly diminished reimbursement rates.").

Second, there is reason to question the position of both defendant and HCFA that it would be nearly impossible to apply the Boren requirements to out-of-state providers. It appears that states with fewer resources than California have complied with the Amendment in reimbursing out-of-state hospitals. See e.g., West Virginia Univ. Hosp., 885 F.2d at 29. In addition, plaintiff provides summaries, taken from the Medicare and Medicaid Guide, of the approaches the different states have taken to reimbursing out-of-state facilities. Johnson Decl., Exh. L. These summaries suggest that many states, while using different methodologies, attempt to

comply with Boren Amendment requirements, such as providing DHS payments. [5] Id.

Indeed, as plaintiff notes, there is nothing indicate that the impracticalities HCFA and defendant describe are necessary with respect to out-of-state hospitals. To begin with, many of the regulations they cite as being particularly onerous, such as uniform cost reporting and period audits, apply to "participating providers", those facilities enrolled in a state's Medicaid program. 42 C.F.R. § 447.253. While it would make sense to enroll the border hospitals that serve a high percentage of another state's residents, most out-of-state providers who care for another state's residents on an emergency basis would not need to be subject to the same administrative requirements imposed on enrolled providers. For example, it appears that Georgia uses prospective rates only for enrolled out-of-state hospitals. It pays non-enrolled out-of-states hospitals at rates consistent with the other state's rates under the Medicaid program or at a specified percentage of allowable costs. Johnson decl., Exh.L. at 2 This kind of flexibility of methodology is consistent with the law of the Ninth Circuit, which holds that even respect to in-state-providers,

> the states are free to create their own methods of arriving at the required findings and that the finding process does not require any special studies or written findings. It is sufficient if the state agency has considered, on the basis of some reasonably principled analysis, whether its payment rates meet the substantive requirements of the Boren Amendment.

Folden, 981 F.2d at 1057; accord West Virginia Univ. Hosp., 885 F.2d at 29 (emphasizing that Pennsylvania may formulate reimbursement system for out-of-state hospitals without empirical evidence of historical costs of operation as long as rates are reasonable and adequate under Boren Amendment). It is worth noting that it seems Congress, by adopting the Boren Amendment, was attempting to diminish rather than exacerbate the administrative burdens on states by creating more flexibility. S. Rep. No. 97-139, 97th Cong. 1st Sess. 478, reprinted in 1981 U.S.

Code Cong. & Admin. News 744; Wilder, 496 U.S. at 515. The fact that Congress did not achieve that result or the fact that a state may make it more complicated than it must are not factors relevant to the present inquiry.

Furthermore, plaintiffs suggest that California previously used a reimbursement scheme that would be acceptable under the Boren Amendment. Plf's Opp. At 15 & n.6. The prior scheme apparently allowed for a number of different reimbursement methods depending on the availability of information. Johnson Decl., Exh. J.

It is not within the province of this court to devise a workable reimbursement scheme for out-of-state providers, but it is within its duties to determine if the arguments of impracticability square with Congress' intent in enacting the Boren Amendment. Cardoza Fonseca, 480 U.S. at 448. The court finds that they do not.

C. Statutory Interpretation

1. The Text

The plain meaning rule requires courts to look first to the plain meaning of a statute's language when endeavoring to interpret it. Alemero v. I.N.S., 18 F.3d 757, 760 (9th Cir. 1994); Appendix: The Rehnquist Court's Canons of Statutory Construction, 108 Harv. L. Rev. 97, 97 (1994) [hereinafter "Canons"]. There can be little disagreement that an analysis of the text of the Amendment is ultimately unavailing. The Amendment says nothing more than "hospital services."

While defendant insists that the language of the Amendment requires intimacy with a facility and state control and as such precludes its application to out-of-state hospitals, this interpretation overreads the statute. Where the plain language does not create a distinction or exception, it would be foolhardy for a court to presume one exists. Canons, at 105 ("Presumption against creating exemptions in a statute that has none.") (footnote omitted). Rather the presumption should go in the other direction: unless reliance on other interpretive canons provides a

reason to believe Congress intended to exclude out-of-state hospitals from the hospitals referred to in the Boren Amendment, then the term used should be given its full and natural meaning.

While not dispositive, it is informative how other courts have interpreted the language of the Boren Amendment. No court appears to have ever squarely addressed the particular question of whether reimbursement methods for out-of-state hospitals must comply with the Boren Amendment, but the Third Circuit by implication concluded that they must.[6] In West Virginia Univ. Hosp. that court found that Pennsylvania's reimbursement rate for nearby West Virginia hospital violated the requirements of the Boren Amendment. 885 F.2d at 29.

At issue in West Virginia Univ. Hosp. was the reasonableness of Pennsylvania's reimbursement scheme as it applied to a large teaching hospitals in West Virginia located six miles from the Pennsylvania border. Although the case is distinguishable on the facts, and could plausibly be read narrowly to apply to border hospital like WVUH only, the court's analysis of Pennsylvania's reimbursement rate applies to all out-of-sate hospitals. In fact, despite the court's failure to hold specifically on the preliminary question of the Amendment's applicability, it nonetheless scrutinized the statutory language for its relevance to out-of-state hospital:

> Nothing is section 1396a(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines; it nowhere suggests that the state boundary lines act as points of demarcation in reimbursement for the delivery of health care. Under the federal regulations . . . state boundary lines, except for administrative responsibility, bear an insignificant role, if any, with respect to the actual delivery of health care in a program designed on a national level to aid the poor in a highly mobile society. Id.

While the text of the Boren Amendment itself makes no distinction between in-state and out-of-state hospitals, the presumption that no distinction was intended is buttressed by the

fact that Congress included language elsewhere in the statute that does make exact distinction. Where a state plan includes medical assistance for services in an intermediate care facility for the mentally retarded, Congress required periodic on-site inspections of each such facility "within the state". 42 U.S.C. § 1396a (a) (31) (B) (emphasis added). At a minimum this language supports the notion that Congress is capable of making a distinction between in-state and out-of-state providers when it chooses to.

That Congress did not intend to distinguish between in-sate and out-of-state providers is further support by the legislative history. The Senate Report states that under the Boren Amendment "States would be free to establish rates on a statewide or other geographic basis, a class basis, or an institution-by-institution basis, without reference to medicare principles of reimbursement." S. Rep. No. 97-139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong. & Admin. News 744. This statement suggests Congress was not assuming rates would be set under the Amendment according to state boundaries.

The fact of the matter is that the language of the Boren Amendment does not distinguish between in-state and out-of-state hospitals, and this court is unwilling to create distinctions where non exists. As defendant herself says in her unnecessarily strident reply, referring to other distinctions, "The Boren Amendment makes no such distinctions . . . that's the way it is. That's the way Congress wrote the act." Def's Reply at 12. Of course, the way Congress wrote it applies with equal force to both parties. Although defendant spends a great deal of time castigating plaintiffs' analysis and decrying the burdens of the Amendment if applied to out-of-state providers, she offers little in the way of cogent analysis on her own behalf. A careful reading of the statute does not support her position of the one HCFA announces in its amicus brief.

2. The Structure of the Act.

A statutory provision should be read in such a way as to maintain the textual integrity of the entire statute by not rendering

other provisions superfluous or inconsistent with the structure of the statute. Canons, at 98-99.

Defendant argues that the Social Security Act is structured such that other provisions apply to reimbursing out-of-state hospitals and exclude application of the Boren Amendment. Specifically, defendant contends that section 1396a (a) (16) and HCFA's regulation implementing that section, 42 C.F.R. § 431.52, provide for an alternative method of payment for out-of-state services.

Section 1396a (a) (16) requires a state medical assistance plan to "provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom . . . ." In 1991 HCFA amended the regulations implementing this section.[7] 56 Fed. Reg. 8832, 8847 (Mar. 1, 1991) (codified at 42 C.F.R. § 431.52). The regulations require that

> [a] state plan must provide that the State will pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:
>
> (1) Medical services are needed because of medical emergency;
>
> (2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;
>
> (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
>
> (4) It is general practice for recipients in a particular locality to use medical resources in another State.

42 C.F.R. § 431.52(b).

According to defendant, these regulations and section 1396a (a) (16) of the statute are the only provisions regulating out-of-state coverage, and they exhibit a clear Congressional desire to treat out-of-state hospitals separately, albeit equally. Specifically, defendant contends that section 431.52(b) of the regulations provides the entire federal guidance on reimbursement of out-of-state hospitals; so long as states reimburse out-of-state hospitals fairly they needn't follow the Boren requirements.

In response, plaintiff argues that "to the same extent" should not read to impose a separate standard, but to require the same standard for both in-state and out-of-sate hospitals, namely the standard articulated in the Boren Amendment and its accompanying regulations. To support this contention plaintiff relies on the district court's conclusion in West Virginia Univ. Hosp. that section 431.52 does not provide a basis for treating out-of-state hospitals differently because the "regulation is not directed towards the treatment of hospitals but towards the treatment of medicaid recipients." West Virginia Univ. Hosp. Inc. v. Casey, 701 F. Supp. 496, 519 (M.D. Pa 1988), aff'd in part and rev'd in part on other grounds, 885 F.2d 11 (3d Cir. 1989), aff'd on other grounds, 499 U.S. 83 (1991).

Plaintiffs' reliance here is not fruitful. While plaintiff is right that section 431.52 enumerates those instances when recipients will be eligible for medical services when out of their own state, the list is principally relevant to determining when the recipients home state must pay for services rendered elsewhere. It does not address how reimbursement for those services should be made. Deciding that the regulation relates to payment of hospitals does not aid in determining what it means about that payment. Interpreting the phrase "to the same extent that " to mean out-of-state hospitals must receive the same kinds of payments in-state hospitals receive, perhaps even including disproportionate share payments as required under Boren is consistent with the structure of the statute.[8] Whether this requires

the same methodology for calculating the reimbursement based on those requirements is another question.[9]

Most compelling in HCFA's own interpretation of its regulation, an interpretation entitled to substantial deference. Thomas Jefferson Univ., ___ U.S. at ___, 114 S. Ct. at 2386; accord, Providence Hosp. of Toppenish, 52 F.3d at 216. According to HCFA, section 1396a (a) (16) and section 431.52, its implementing regulation, are directed only to coverage and not to reimbursement levels. It provides the example of a state plan that covers a heart transplant; that state must pay for a heart transplant for a state resident when she is out of the state provided she meets the conditions of section 431.52. According to HCFA the section says nothing about how much the state will pay for that heart transplant or how its payment will be calculated. HCFA argues that the placement of section 431.52 within the Code also supports its interpretation. It is found in Part 431 governing general administration and not Part 447 which addresses payment for services.

Instead, HCFA proposes that section 1396a (a) (30) of the Medicaid statute and its implementing regulations govern the reimbursement levels for out-of-state providers. Section 1396a (a) (30) (A), known as the "equal access" provision, requires a state plan to

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficient, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic areas...."

42 U.S.C. § 1396a(a)(30)(A). HCFA asserts that this section, rather than the Boren Amendment, serves as a less burdensome guarantee that reimbursement rates will not be so low that they

discourage providers from treating out-of-state Medicaid beneficiaries.

HCFA's interpretation of section 1396a (a)(30)(A) is simply untenable. As the agency concedes, to the extent the section serves as a safeguard against inadequate payments, it only does so in the context of two of the four situations in which out-of-state recipients are served: in border hospitals and where the needed services are more readily available out-of-state. 42 C.F.R. § 431.52 (b) (3) & (4). The other two situations in which a provider would treat an out-of-state Medicaid beneficiary are both in cases of emergency. Under those circumstances the section is presumably inapplicable because a provider does not have a choice to refuse treatment and therefore a promise of adequate payment would not affect the availability of services. The equal access provision is tailored to create an incentive for facilities that are not otherwise obligated to provide care to Medicaid recipients. It simply does not make sense as a general protection against inadequate reimbursement.

Moreover, as plaintiffs argue, the legislative history of the equal provision suggests it is directed at noninstitutional providers. The House Report refers to access to and inducement of physicians rather then facilities. H.R. Rep. No. 247, 101st Cong., 1st Sess. (1989), reprinted in 1989 U.S.C.C.A.N. 2060, 2115-16. The Eight Circuit has made the distinction explicit, noting that the Boren Amendment governs institutional providers and the equal access provision governs noninstitutional providers. Arkansas Medical Soc. Inc., v. Reynolds, 6 F.3d 519, 522 n.2 (8th Cir. 1993). While the Ninth Circuit has not ruled on this issue directly, cases suggest an application of the two provisions that is consistent with the interpretation of the Eight Circuit. Compare Clark v. Coye, 60 F.3d 600(9th Cir. 1995) (applying equal access provision to reimbursement of dentists) with Folden, 981 F.2d 1054 (applying Boren Amendment to nursing homes).

3. The Purpose of the Act

Ambiguous statutes should be interpreted "so as best to carry out their statutory purposes." Canons, at 105 (citing Reves v. Ernst & Young, 494 U.S. 56, 60-61 (1990)). In divining the

purpose of a statute, it is not uncommon to make use of extrinsic sources such as the legislative history.

Defendant argues that the purpose of the Boren Amendment was to provide states with flexibility in setting reimbursement rates, and that to burden them with the responsibility of applying its requirements to out-of-state hospitals would be antithetical to the Amendment's purposes.

Defendant is correct that one purpose of the Amendment was to provide states with flexibility in developing the payment rate for inpatient hospital services, as well as to encourage efficiency and lower medical costs. See Wilder, 496 U.S. at 515 n.13 (detailing the legislative history of the Boren Amendment); Colorado Health Care Ass'n v. Colorado Dept. of Social Serv., 842 F.2d 1158, 1165-66 (10th Cir. 1988) (analyzing the Congressional intent behind the Amendment). However, as the Senate Report points out, the flexibility was "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 97-139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong, & Admin. News 744, see also Wilder, 496, U.S. at 515 ("In passing the Boren Amendment, Congress sought to decentralize the method for determining rates, but not to eliminate a State's fundamental obligation to pay reasonable rates.") (Citation omitted). Thus, in enacting the Boren Amendment for the purposes of encouraging efficient hospital management and affording states administrative flexibility, Congress remained attentive to the broader purposes of the entire Medicaid program, which was to provide health care to low-income people. See e.g.,, West Virginia Univ. Hosp. , 885 F.2d at 23 (explaining that the states' discretion was limited by Congress' desire to ensure that Medicaid have access to services and that disproportionate share hospitals are not discouraged from treating Medicaid patients due to inadequate support).

Any judicial interpretation of the Boren Amendment should be responsive to the broad goal of Medicaid to ensure that the needy receive proper care and that hospitals have the proper incentive to provide that care. As the court noted in West Virginia Univ. Hosp., "[t]he `ultimate touchstone' of the Boren

Amendment is whether `a reimbursement policy will alter the availability of or quality of care to be provided. . . .'" 701 F. Supp. At 518 (quoting Friedman (S.D.N.Y. 1987)). In as much as the Boren Amendment was a sophisticated attempt to fulfill that goal while at the same time encouraging efficiency, it makes little sense to remove out-of-state hospitals from that worth rubric.

In short, because the equal access provision cannot provide a general guarantee that providers who care for out-of-state Medicaid beneficiaries will be adequately reimbursed, HCFA'a position that the Boren Amendment does not apply to out-of-state providers runs counter to Congressional interest, for it leaves inexplicable gaps in the ability of out-of-state hospitals to recover reasonable rates for the services they are obligated to render.

To the extent the Boren Amendment affords flexibility in determining in-state payment rates, it allows the same flexibility in determining out-of-state rates. Defendant cannot simultaneously argue that Boren is an administrative straightjacket as applied to out-of-state hospitals and a model of state discretion and localism as applied to in-state facilities. What works (or malfunctions) for one, works for other.

CONCLUSION

For the reason set forth above, this court hereby DENIES defendant's motion for summary judgment and concludes that the Boren Amendment applies to out-of-state providers.

IT IS SO ORDERED.

Dated: _____

_____

MARILYN HALL PATEL
United States District Judge

ENDNOTES

1. It is worth noting that Chevron, U.S.A., Inc v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984), the seminal case deference to agency interpretation, was decided in the context of Supreme Court review of an administrative regulation. Other cases appear to assume that an agency's construction of a statute would take the form of adjudication or rulemaking. See e.g., F.E.C. v. Democratic Senatorial Campaign Comm., 454 U.S. 27, 32 (1981).

2. In their January 21, 1993, response to CDHS, HCFA listed 12 separate assurances that it concluded complied with its regulations implementing the Boren Amendment. Johnson Decl., Exh. D. at 1-2.

3. A prospective rate-setting system establishes a pre-set rate each provider will receive and encourages providers to be efficient in order not to absorb the loss they would incur if their actual costs exceed the predetermined rate. Folden, 981 F.2d at 1056

4. According to HCFA, it is a state's licensure laws that typically determine a facility's costs by mandating personnel requirements, equipment technology, etc. HCFA Amicus Brief at 12-13.

5. HCFA takes the position that DSH payments are not required for out-of-state providers, but states may choose to make DHS payments to qualifying out-of-state providers and still receive some federal reimbursement. HCFA Amicus Brief at 17 n.6. However, it would be surprising indeed if states made Dsh payments they were not required to make, despite federal assistance.

6. The district court in Multicare Medical Center assumed that the Boren Amendment requires a state to make

disproportionate share payments at least to border hospitals. Multicare Medical Center, 768 F. Supp. at 1401 (citing West Virginia Univ. Hosp.). However, there seems to be even less evidence in the statutory language for distinguishing between border hospitals and other out-of-sate hospitals than between in-sate and out-state hospitals.

7. Contrary to plaintiffs' suggestion, section 431.52 was not adopted for the first time in 1991. According to HCFA, the section has been codified in substantially its present form since 1978. 43 Fed. Reg. 45-176, 45, 189 (Sept. 29, 1978); see HCFA Amicus Brief at 21-22 (detailing history of section 431.52.). HCFA states that the 1991 amendment merely changed its location within the Code and was not substantive.

8. The grammatical construction "to the same extent that" is comparative in nature and does not stand alone, thus it must be understood in conjunction with whatever statutory provision articulates the "extent" of either hospital coverage or reimbursement , depending on how one reads the regulation. This court refers to HCFA for the interpretation of its own regulation.

9. As noted above, while the court in West Virginia Univ. Hosp. found that Pennsylvania has to make disproportionate share payments and generally abide by the Boren requirements when paying out-of-state hospitals, it declined to hold that "Pennsylvania must apply precisely the same methodology to WVUH and other out-of-state hospitals as it does for its in-state hospitals if there is a rational basis for a departure." 885 F.2d at 29.

APPENDIX D

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must -

(13) provide -

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel

time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

APPENDIX E

H.R. 2015

Balanced Budget Act of 1997 (Enrolled Bill (Sent to President))

SEC. 4711. FLEXIBILITY IN PAYMENT METHODS FOR HOSPITAL, NURSING FACILITY, ICF/MR, AND HOME HEALTH SERVICES.

(a) REPEAL OF BOREN REQUIREMENTS-Section 1902(a)(13)(42 U.S.C. 1396a(a)(13)) is amended-

(1) by striking all that precedes subparagraph (D) and inserting the following:

(13) provide--

A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs,

(2) by redesignating subparagraphs (D) and (E) as subparagraphs (B) and (C), respectively;

(3) in subparagraph (B), as so redesignated, by adding 'and' at the end;

(4) in subparagraph (C), as so redesignated, by striking 'and' at the end; and

(5) by striking subparagraph (F).

(b) STUDY AND REPORT-

(1) STUDY-The secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).

(2) REPORT-Not later than 4 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

(c) CONFORMING AMENDMENTS-

(1) Section 1905(o)(3)(42 U.S.C. 1396d(o)(3)) is amended by striking 'amount described in section 1902(a)(13)(D)' and inserting 'amount determined in section 1902(a)(13)(B).'

(2) Section 1923 (42 U.S.C. 1396r-4) is amended, in subsections (a)(1) and (e)(1), by striking 1902(a)(13)(A)' each place it appears and inserting '1902(a)(13)(A)(iv).'

(d) EFFECTIVE DATE-This section shall take effect on the date of the enactment of this Act and the amendments made by subsections (a) and (c) shall apply to payment for items and services furnished on or after October 1, 1997.